The Manitoba Medical Review

Vol. 29 OCTOBER, 1949 No. 10

DERMATOLOGY

The New and the Old in the Treatment of Common Skin Diseases

Arthur R. Birt, M.D.

The treatment of skin diseases is an ever present problem amongst those engaged in the practice of general medicine. All of you are aware of the old and tried methods of treating various dermatoses. These methods have been built up over many years, usually by the process of trial and error, and now prove adequate for the treatment of a very large proportion of all skin diseases. The medications used can be found in any of the official formularies, such as the British Pharmacopeia and the Canadian Formulary, and they have the added advantage of being reasonable in cost and relatively easy to prepare. It is well to remember this. We have all, during the past few years been exposed to an unending procession of new drugs. Each has been heralded, usually in a popular magazine as a miracle drug, and then has arrived, accompanied by a fanfare of multi-colored pharmaceutical literature. There is a tendency amongst many of us to accept anything that is new as an advance. It is indeed a great temptation to accept all these drugs at their supposed values, and to ignore experience, which has so often taught us to be cautious in evaluating new treatments. Undoubtedly some of the new drugs will stand the test of time and become valuable additions to our therapy. In the meantime, it would seem to be wise to treat our patients with routines that we know to be reliable from past experience; and only to try the new when they have failed, or when there is some very definite indication.

Today I propose to give you my opinion of the relative values of some of the new drugs as compared to the old and to point out how our therapy of some of the commoner skin diseases has changed.

(1) Diseases Due to Animal Parasites:

A. Pediculosis. The treatment of pediculosis capitis has been revolutionized by the advent of D.D.T. Ten per cent of the drug is used in talcum powder and shaken into the scalp from a powder box with a perforated top, care being taken to get the powder right down to the scalp, all over the head. After 24 hours the head is washed with soap and water and the patient is regarded as cured. This treatment does not remove the nits. Buxton has said that "a dead nit is a joy to the eye of the dermatologist." Unfortunately, this is a pleasure I have missed, as I can never be sure if a nit is alive or dead just by looking at it. However, the entymologist at the Children's Hospital has examined nits from the scalps of patients treated as long as six months previously, and has never found any that were viable. The City of Winnipeg Health Department now allows children to attend school as soon as they have been treated, and it is no longer necessary for them to stay at home for the long periods of time required to remove all nits. It is important, and easy, to treat all infected people in the household at the same time. D.D.T. must not be applied in an oily or greasy base, as it can be very toxic if absorbed. This therapy is also used for the treatment of pediculosis corporis, and less commonly for the treatment of pediculosis pubis, where unguentum hydrargyri (blue ointment) is still quite adequate.

B. Scabies. Benzyl Benzoate has been very popular in the treatment of scabies during the past decade. It is easy of application and does not restrict the patients' activities. Unfortunately, it produces a considerable amount of dermatitis and has a treatment failure rate of at least twenty per cent. After giving the drug a very adequate trial at the Children's Hospital and becoming aware of its shortcomings, we stopped using it more than 4 years ago. The same opinion was expressed by others at the Section of Dermatology, Canadian Medical Association meeting in Saskatoon this year. Sulphur, in some form, is still the best method of treating scabies. In our experience, Danish Ointment, C.F. (Scabicide) is the application of choice, if the 24-hour routine is followed.

(2) Diseases Due to Pyogenic Infection:

It is in the field of pyogenic infections that some of the most important new drugs have been introduced, and it is still too early to accurately assess all of their values.

A. Impetigo Contagiosa. The results obtained in treating impetigo contagiosa will vary with the depth of the infection and the causative organism. The very superficial, bullous type of impetigo with brown crusting is usually caused by staphylococci and as a rule will respond quicker to the new antibiotics than do the deeper, more heavily crusted and follicular lesions that are probably caused by streptococci. The sulphonamides, because of their great ability to sensitize an individual when applied to a broken skin area, should never be used in local therapy. It is entirely wrong to deprive anyone of the life saving qualities of sulphona-

Read at the Annual Meeting of the Manitoba Medical Association, Winnipeg, September 22nd, 1949.

mides by needlessly sensitizing them while treating such a superficial infection as impetigo. Penicillin will produce dramatic results in the treatment of superficial staphylococcal impetigo, but is not very effective if applied locally for the deeper types of infection. Penicillin ointment should be prepared freshly and kept in a refrigerator. About 400 units to the gram of eucerinum makes an effective ointment that will last for about six weeks if kept cold. Most penicillin ointments sold in tubes do not compare favorably on clinical trial with freshly prepared ointment. It also has the advantage of being reasonable in price, but the disadvantage of being useless unless kept cold. Mercury in the form of ungentum hydrargyri ammoniata is still the most acceptable application for the treatment of impetigo. Mercury is apparently not concerned whether organisms are gram positive or gram negative and produces equally good results in all pyogenic infections. It has the added advantage of rarely being used by mouth and the possibility of sensitization becomes less important. Bacitracin, a new antibiotic developed from strains of B. Subtilis, is also useful in the treatment of superficial pyogenic infections. It is used in ointment form in a concentration of 500 units to a gram of ointment base. It has a very low sensitization rate and tends to depreciate quickly unless refrigerated. At the present time it is expensive. Bacitracin may prove useful when it is more stable and more readily available to the patient. Tyrothricin ointment has not been effective in our experience. The flavines, in the form of Furacin ointment, are messy; apt to produce dermatitis; and are not very effective therapeutically.

B. Sycosis Vulgaris and Furunculosis. The antibiotics are not very useful in the local therapy of follicular pustular eruptions. However, their oral and parenteral administration has changed the whole treatment of boils and carbuncles. Penicillin, at the moment, is the most commonly used and is the most effective. It is usually administered as procaine penicillin G. This type of therapy cures the lesions that are present, but does nothing to raise the patients' resistance to the infection. In the event of recurrent infection, it is wise to combine penicillin therapy with a course of staphylococcus toxoid. Quinilor ointment (chloro-hydroxy-quinoline) is a most useful adjunct in the treatment of small follicular pustules and sycosis vulgaris.

Recently, in the city of Winnipeg, there has been a pyogenic infection of epidemic proportion in the new born and their mothers. The lesions in the infants appear within a few days of birth and are small, superficial, follicular pustules and many of the mothers develop breast abscesses six to eight weeks later. The organism recovered is a hemolytic staphylococcus aureus, that is grouped as phage type W (designated W for Winnipeg by Dr. Colbeck). The organism is very resistant to penicillin and is quite sensitive to aureomycin. It has been possible to control the infection in the Winnipeg General Hospital by administering aureomycin 25 mgm. T.I.D. to all infants for the first three days of life. Again the drug does nothing to raise the patients' resistance and repeated courses of the medication may have to be given along with staphylococcus toxoid in persistent, older infections.

(3) Diseases of Allergic Origin:

A. Urticaria. The management of acute urticaria has been simplified by the advent of the anti-histaminic drugs. In our hands pyribenzamine or neoantergan, 50 mgm. q.i.d. have proven quite effective, and are not as toxic as Benadryl. There are countless other anti-histaminic drugs on the market, but it is far too early to accurately assess their value. In chronic urticaria the anti-histaminic drugs help control the eruption but often fail to produce a cure.

B. Atopic and Contact Dermatitis. The oral administration of anti-histaminic drugs occasionally, and for a limited time, only, helps to control the tendency to scratch in atopic and contact dermatitis. It is possible that this response is due to the sedative action of the drugs. The local use of anti-histaminic drugs is more apt to produce trouble than to have a beneficial effect. The main benefit from their application can be expected in the treatment of localized thickened pruritic lesions. Altogether these new drugs have proven a disappointment in the treatment of atopic and contact type dermatitis. The best local therapy for this form of dermatitis is still to be found in the official formularies. Aluminum acetate compresses, potassium permanganate baths, calamine lotion and liniment, Lassar's paste and zinc ointment, while very commonplace applications, will pay dividends to the physician who will learn how and when to apply them and when and how to remove them. Tar is still a very useful remedy for chronic weeping and lichenified areas of dermatitis. Recently an improved tar known as Zetar has been marketed. It has all the advantages of crude coal tar, including the color, and yet it can be washed off. It is prescribed in 2-5 per cent strength in a zinc oxide or vaseline base. A word of warning regarding the use of ointments whose name contains the word "caine" is probably not amiss. These ointments, like their famous namesake in the Book of Genesis, are very apt to cause a considerable amount of trouble.

(4) Diseases Due to Fungous Infections and Psoriasis:

During the past few years various fatty acids and their salts have been used in the local therapy

of superficial fungous infections of the skin. Undecylenic acid and propionic acid and their salts have proven to be the most useful members of the group. They are sold commonly under the trade names of Desenex and Sopronol. Their main use has been in the treatment of epidermophytosis, where their action would seem to parallel but not exceed that obtained by older remedies such as Whitfield's ointment. Recently Perlman experimented with the oral administration of undecylenic acid in an attempt to cure tinea capitis. The exfoliation it produced led him to try it in the treatment of psoriasis. Like many new treatments, its virtues were proclaimed prematurely and were exalted in the public press. Unfortunately, for the psoriatic, Perlman's pearls have been found wanting. They do have some effect on psoriasis, but apparently seldom eventuate in cure. While taking them the patient suffers greatly with an abdomen distended with gas, which, when belched, tastes of rotten herring.

These then are some of the new things in dermatology. There are many others, including the use of podophyllin in the treatment of venereal warts; Bal in arsenical dermatitis; Vitamin D2 in lupus vulgaris and Vitamin E in lupus erythematosus, and countless others.

Recently I heard my barber say he could give any girl the "new look," providing she had all the old parts. If any of you plan to achieve the "new look" in dermatology be sure that it is laid on the old and true foundation.

In closing I would like to quote some remarks made by Marcus Caro in a paper read at the American Academy of Dermatology and Syphilology last year:

"A clinical dermatologists' chief function (and most of us are primarily clinicians) is to bring to his patients relief from suffering. To this end he should utilize all measures of established merit that apply to each case. For this vocation most of us are well trained. It has become popular in recent years, however, for many dermatologists to become clinical investigators for every new drug and proprietary mixture that is brought to the market. For this highly critical function most of us are not adequately equipped. Not many have a large enough group of patients to investigate fully the effects of a drug, including the controls essential to an accurate appraisal. Many clinical investigators as yet lack the mature judgment needed to temper their enthusiasms and to keep them from being carried away by clinical impressions that may not be lasting. In dermatologic therapy too many of us are attempting to run who have not yet fully mastered the art of walking. It may seem antiquated to use old drugs, and old fashioned to treat patients with the simple purpose of getting them well as quickly as possible. Certainly there is more glamour in being up-to-the-minute with the use of the newest drugs and even ahead of the time in the investigation of drugs for which no disease has yet been found. Most of us dermatologists, in my opinion, are most useful, however, when we devote ourselves wholeheartedly to the career of being a healer of the sick. It is an old fashioned role, devoted largely to treating diseases that are not new, and most often calling for the employment of drugs that have been tested in the crucible of time. It is an honorable career and a satisfying one, a career to which, in our highly scientific age, we particularly need converts."

CANCER

Edited by D. W. Penner, M.D.

Fibrosarcoma — The Malignant Tumor of Fibroblasts

Abstract

Stout, Arthur Purdy (Presbyterian Hospital, New York, N.Y.). Fibrosarcoma—the Malignant Tumor of Fibroblasts. Cancer, 1:30, May, 1948.

This paper presents a critical discussion of some of the more important literature on the subject, plus an analysis of 218 cases from Columbia University.

There has been some confusion of terminology and diagnostic criteria. Some, confessing inability to determine the origin of the tumor, name it by the shape of cells, e.g. "spindle cell sarcoma." Others call almost any spindle-cell tumor "neurogenic sarcoma," on the assumption, considered false by the author, that they arise from peripheral nerves. He recommends that the term be dropped.

The author questions the diagnosis in many of the reported cases, suggesting that some may be leiomyosarcomas, rhabdomyosarcomas, liposarcomas, mesenchymomas, undifferentiated osteogenic sarcomas, etc. Naturally such errors in diagnosis have influenced present opinions regarding prognosis. He believes that such errors have been largely eliminated from the Columbia series by a very searching investigation and analysis.

The author divides fibroblastic growths into three main categories:

A—Non-neoplastic fibrous growths: This includes:

(1) The so-called pedunculated skin fibroma (a pedunculated skin tag with a fibrous core).

(2) Keloids—an overgrowth of scar tissue, common in Negroes.

(3) Hereditary polyfibromatosis—a rare condition with multiple nodules usually appearing at age 2 or 3 years, which may ossify, and is then called progressive myositis ossificans.

B—A group which may or may not be neoplastic: These are almost always benign, and usually do not reappear after complete excision.

(1) True intradermal fibromas—These are intradermal or subcutaneous areas of fibroblastic tissue, which are of 2 types:

(a) Composed entirely of fibrous tissue. The smaller ones do not recur after excision. The larger ones may show continuous local progressive infiltrative growth, recurring after excision, and generally called fibrosarcoma. There is no histological method of differentiating the recurring from the non-recurring, and one must rely on size and growth.

(b) A fibroblastic tissue with considerable vascularity, and often phagocytes. This is called fibrous xanthoma, or sclerosing hemangioma, and is always benign.

(2) Desmoid tumors—These probably arise in the connective tissue of muscle which has been stretched during pregnancy or operation. They do not recur if completely removed. He reports 12 cases treated with excision, with no recurrences. He believes that some cases which show recurrence are not desmoids, but true neoplasms, such as fibrosarcomas and myosarcomas. It may be impossible to make the differentiation solely on the histology.

(3) Fibrous proliferations of palmar and plantar fascia—This is sometimes associated with Dupuytren's contracture, and sometimes without. It may form tumor-like nodules. Histologically, it may be similar to, or identical with, a desmoid or a fibrosarcoma.

(4) Irradiation fibromatoses—Just as malignant epithelial tumors may result from irradiation of skin and mucus membranes, so do tumors occasionally develop in fibrous tissue following radiation. Some of these are truly malignant fibrosarcomas, others benign.

C—True Fibrosarcomas: The outstanding feature is infiltrative growth. Two types may be distinguished:

(1) A non-metastasizing group in which growth may be slow and steady, or showing long static periods. Most fibroscarcomas fall into this group, including skin fibrosarcomas, dermatofibrosarcoma protuberans (firm pedunculated nodules which tend to recur unless widely excised), breast, mesenteric, omental and retroperitoneal tumors, periosteal fibrosarcomas (endosteal fibrosarcomas are probably mis-diagnosed osteogenic sarcomas or chondrosarcomas; parosteal fall into the next group), and fibrosarcomas in many other parts of the body. Rarely tumors of this group may become less differentiated and assume the features of the next group.

(2) The less differentiated, more malignant fibrosarcomas with more rapid growth. The best single means of differentiating the 2 groups is by the number of mitoses, although other histological criteria are given. This group includes parosteal fibrosarcoma, and many of the most important group of all—fibrosarcoma of the soft parts of the head, neck, trunk and extremities. Previously published reports conclude that this is an extremely serious group, with a high death rate, especially when in the thigh, ranging around 60%. The present series includes 144 fibrosarcomas of these parts, and while the recurrence rate was 60%, only 8% metastasized, and only 20% had died of the disease 10 years after its appearance. It was also found that those tumors arising in the thighs, muscles, tendons or tendon sheaths carried only a slightly higher death rate, than in other areas. The difference in outcome is attributed to the more accurate diagnoses in the present series.

Diagnosis should be established by biopsy.

Treatment: If the tumor is well differentiated, local excision will suffice, but it is most important that excision be beyond the palpable margins, since the time to cure them is at the first operation, and sacrifice of a little extra tissue on all sides may save the patient many subsequent operations and perhaps his life.

If the tumor is anaplastic, more radical surgery is needed. It should include local amputation of an extremity if there is any possibility that local excision will fail, for, while metastasis can occur, it is relatively infrequent, and the chance of saving life quite good. In all cases in this series metastasis was by blood stream, but lymphatic spread has occurred rarely. However, this is so uncommon that removal of regional nodes is unnecessary unless involved.

Although the majority are radioresistant, the occasional one is not, and radiotherapy may have some place in treating the occasional case of multiple recurrences after surgery.

L. C. Bartlett

GYNECOLOGY

Edited by R. Lyons, B.A., M.R.C.S., L.R.C.P., M.R.C.O.G.

Advances in Placental Biochemistry

A. A. Earn, M.D., M.Sc. (Med.)*

This review is presented to indicate the advances made in the various fields of placental biochemistry. Tissue culture, histochemistry, simultaneous foetal and maternal blood chemistry, tissue extracts, and tracer substances have been among the methods used during the investigations.

The placental barrier cannot be completely explained on the basis of a Donnan equilibrium. The levels of the constituents in the maternal blood differ from those of the foetal blood. The rate of transfer across the placental barrier increases with maturity[7]. This has led to further investigations of the functional activity of the human placental trophoblast, which appears to synthesize and secrete several different hormones and to promote the catabolic and anabolic requirements of the foetus.

Tissue Culture

Chorionic gonadotropin (A.P.L.) is produced by the cytotrophoblast (Langhans' layer) of the villi. Seegar Jones et al[6] in 1942 and Stewart et al[9] in 1948 cultured cytotrophoblastic tissue. Chorionic gonadotropin was formed in the medium.

Histochemistry

The placental steroid hormones (estrogens and progestogens), are probably produced in the syncytial layer of the villi. Wislocki et al[1, 10, 11] used a combination of histochemical reactions to prove that ketosteroids were present in the syncytial cells and thus inferred the production of steroid hormones by these cells.

Nucleoproteins concentrate in cells where there is active protein synthesis. The cytotrophoblast of the trophoblastic shell and cell columns as well as the syncytial trophoblast shows such a concentration [2, 10]. The amount of nucleoprotein decreases as the placenta matures; while the acid and alkaline phosphatases show a corresponding rise in the the syncytial and Langhans' cells[11].

Phospholipids form part of the structure of mitochondria and the Golgi apparatus. The former are abundant in the syncytial cells during early pregnancy but decrease in number as the placenta grows older. The Golgi apparatus is present in the syncytial and Langhans' cells[11].

Syncytial trophoblast is believed to have a high oxidative activity, and this is shown by the following inference. The cytochrome oxidase-cytochrome C system is believed to provide one of the main energy transfers in animal tissues. The histochemical indophenol oxidase reaction showed the presence of the above system, and therefore inferred that syncytial trophoblast has a high oxidative activity.

Glycogen is prominent in relatively avascular tissues during the first part of pregnancy. The cells of the trophoblastic shell, columns and islands, and of the maternal decidua contain glycogen[12].

Relatively large quantities of iron occur in the syncytium and intercellular matrix during early pregnancy. Micro-incineration and the Turnbull blue reaction have been used to demonstrate the histological presence of iron in the syncytial cells and the intercellular matrix[1].

Blood Chemistry

Foetal and maternal blood constituents vary in their chemical content as follows, according to Needham's review[7].

Richer in Maternal Blood	Same in Foetal & Maternal Blood	Richer in Foetal Blood
Total solids	Urea	Non-protein N
Proteins	Uric Acid	Free Amino N
Total P	Creatinine	Inorganic P
Lipoid P	Chloride	Calcium
Phosphatides		
Neutral Fat		
Cholesterol		
Glucose		
Sedimentation (10 X greater)		Erythrocytes
Fibrinogen		Hemoglobin

Tissue Extracts

Thromboplastin is present in the tissue extracts of placenta and acts as a powerful toxin. The lethal effect is due to intra-vascular clotting[8]. Antithromboplastin, which inactivates thromboplastin, increases in the blood throughout pregnancy. No evidence has been presented in the literature for or against thromboplastin as a factor in toxemia of pregnancy[8].

Tracer Substances

Heavy water and radio-active sodium have been used to study the transfer of water and sodium across the human placental barrier. Hellman and his associates[3, 5] conclude that the human foetus receives across the placenta at the 14th week of gestation 700 times, and at the 31st week 3,800 times as much water as is incorporated in the growing tissues. The placental transfer co-efficient for water was found to be five times as great as that for sodium during corresponding periods of gestation.

Gellhorn and Flexner question the view that amniotic fluid is stagnant and is derived from foetal urine. Heavy water and radio-active sodium

From the Dept. of Pathology, University of Manitoba, Faculty of Medicine, and the Winnipeg General Hospital.
Abstract from section on Biochemistry in a thesis submitted in partial fulfilment of the requirements of the degree of Master of Science to the University of Manitoba.
* Teaching Fellow in Pathology, University of Manitoba and Resident in Pathology, Winnipeg General Hospital.

were used as tracers in their experiments upon guinea pigs[3, 4]. A volume of water equal to that of the foetus flowed in and out of the amniotic sac in one hour. Sodium transfer was 50 times less rapid than the water transfer. Vosburgh et al[13] repeated the above experiments in humans. They found that the water of the amniotic fluid is completely replaced on the average once every 2.9 hours; which disproves the concept that amniotic fluid is stagnant. The rate of transfer of water was found to be five times more rapid than that of sodium.

Summary

Advances in placental biochemistry have been reviewed. The source of the gonadotropins, estrogens, progestogens, nucleo-protein metabolism, phospholipids, oxidative systems, glycogen storage, iron, blood chemistry, thromboplastin, and wate and sodium transfer are briefly described.

References

1. Dempsey, E. W. and G. B. Wislocki, (1944) Endocrinolog 35: 409.
2. Idem, (1945) Am. J. Anat., 76: 277.
3. Flexner, L. B. et al, (1948) Am. J. Obs. & Gynec., 55: 46
4. Gellhorn, A. and L. B. Flexner, (1942) Am. J. Phys., 13 757.
5. Hellman, L. M. et al, (1948) Am. J. Obs. & Gynec., 56: 86
6. Jones, G. E. Seegar, G. O. Gey, and M. K. Gey, (194 Johns Hopkins Bull., 72: 26.
7. Needham, J., (1942) Biochemistry and Morphogenesi Cambridge Univ. Press, pp. 86-93.
8. Schneider, C. L., (1947) Am. J. Phys., 149: 123.
9. Stewart, H. L., E. S. Machtfeld and T. L. Montgomer (1948) J. Clin. Endoc., 8: 175.
10. Wislocki, G. B. and E. W. Dempsey, (1946), Endocrinol ogy, 38: 90.
11. Wislocki, G. B. and H. S. Bennett, (1943) Am. J. Anat 73: 335.
12. Wislocki, G. B., E. W. Dempsey and D. W. Fawcett, (194 Obs. & Gynec. Review, 3: 604.
13. Vosburgh, G. J. et al, (1948) Am. J. Obs. & Gynec., 56 1156.

The Placenta and Its Appendages

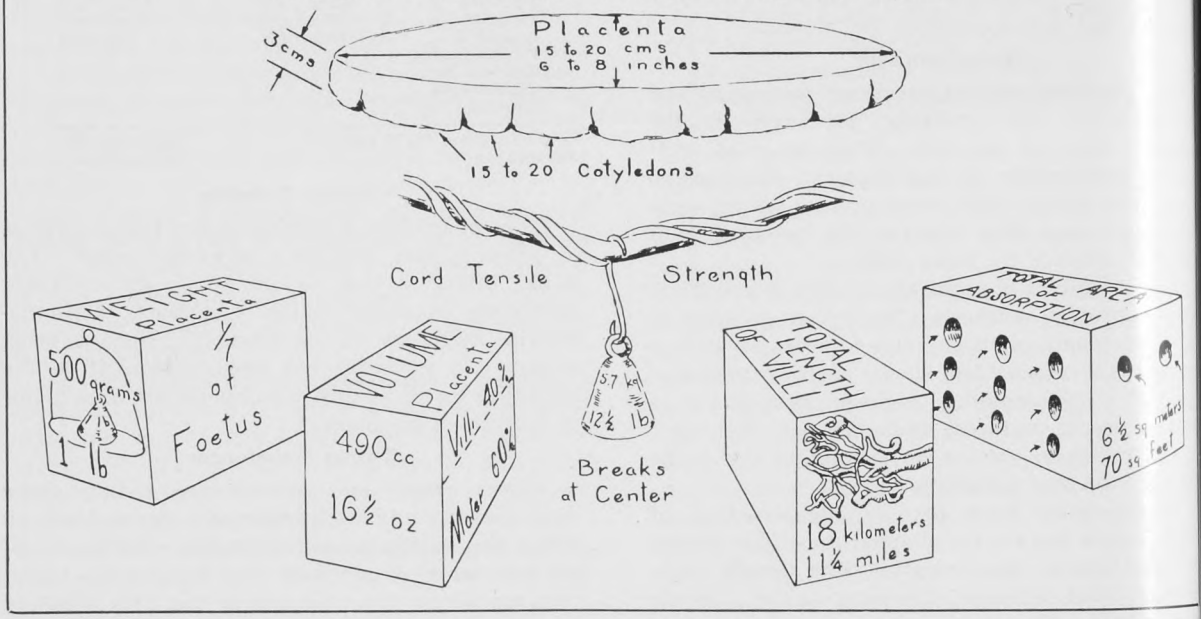
A. A. Earn, M.D., M.Sc. (Med.)*

The normal anatomy of the placenta and its appendages must be known in order to recognize pathological changes. One or two placentas are born every second and although childbirth comprises a substantial proportion of general practice, the placenta receives a very cursory examination.

1. Normal Born Placenta at Term

The human placenta at term, 40 weeks gestation is shaped like a flattened cake. The word placent is derived from the latin, meaning cake (Fig. 1). I measures 15 to 20 cms. in diameter and 3 cms. a its greatest thickness while it tapers at the margin

Figure 1. Placental Measurements, Mainly After Dodds



The normal placenta will be described as at term birth, its appearance in-situ, the cord, the chorionic plate and its cut surface.

The weight is approximately 500 gms. or 1/7 that of the foetus[1, 5, 7].

The maternal surface covered by trophoblastic shell and decidua shows irregular grooves corresponding to the septa which separate the placenta into 15 to 20 cotyledons. Each of these is a placental circulation unit. Every cotyledon is composed of a major stem villus with its system of

From the Department of Pathology in co-operation with the Department of Obstetrics and Gynecology, University of Manitoba and the Winnipeg General Hospital.

Abstract from section on Architecture in a thesis submitted in partial fulfilment of the requirements of the Degree of Master of Science to the University of Manitoba.

* Teaching Fellow in Pathology, University of Manitoba and Resident in Pathology, Winnipeg General Hospital.

branches and free villi. The foetal surface is smooth and regular. It is covered by the vascular chorionic membrane containing the foetal vessels. The amniotic sac is closely applied to the chorion on its foetal side. The membranes are commonly fused at the placental margins and over the non-placental area. The type is hemochorial, that is, the foetal chorion is in direct relationship with the maternal blood. The vessels leave the chorionic plate via the cord. The attachment of the cord is variable. It may be centrally or eccentrically located.

The placental volume has been computed to be around 490 cc. (Dodds)[4]. The foetal villi take up 37 per cent while the maternal lake constitutes 63 per cent. Dees-Mattingly[3] computed higher figures. The surface of the villi is 7 square metres, of which 6.5 square metres (70 square feet) are suited to act as an absorptive organ[4]. The total length of the absorptive villi is 18 kilometres (11¼ miles)[4].

2. Placenta and Membranes "in Situ"

The placental site within the uterus has been extensively investigated by Torpin[10, 11]. This was done by means of amniotic sac distension. The placenta with its almost intact membranes was immersed in a container of water. The amniotic sac was filled with a definite amount of water. It assumed the shape of the uterine cavity, from which it came. In Torpin's series 95 per cent of deliveries showed intact membranes with the exception of the rent over the cervical area produced by the foetal head. The shape of the sac was usually pyriform and most of them assumed lateral bulges over each uterine cornu (Fig. 2).

3. Umbilical Cord

The umbilical cord extends from the foetal surface of the placenta to the umbilicus. The average length is 50 to 60 cms. The diameter may show progressive diminution from the umbilicus to the placenta. Average diameter is 1.2 cms.[8]. There may be localized narrowings. Spirals are frequent, 1 to 22 in number. The windings are right or left. The average tensile strength is 5.7 kilograms (12.5 lbs.)[8]. Rupture occurs usually in the middle.

The cord is covered by an outer epithelial layer. The centre is filled with Wharton's jelly. Enclosed are two arteries, one vein and the obliterated remains of the Allantois at the foetal end.

In the series of Morel and Gernez[6] the umbilical vessels exhibit torsion in 95 per cent of the cords. The right artery is longer than the left and the left is longer than the vein. The calibre of the vein is greater than that of each artery. In 25 per cent the diameter of one artery exceeds that of the other. All three vessels decrease in diameter from placenta to foetus. The arteries anastomose (98.5 per cent) by direct lateral communication near the foetus and by a small vessel (80 per cent) within 2 cms. of the placenta[6].

The umbilical vein frequently shows partial or complete grooves upon its external surface[9] at the site of the twisting. The wall is thin and puckered when empty. The lumen may show transverse or oblique semi-lunar folds[9].

The umbilical arteries[9] show partial or complete constrictions at irregular intervals. The calibre varies throughout their length. Dilatations may be present, measuring from a mm in length to a cylinder 2 cms. long. The dilatations are called nodules or valves of Hoboken (who described them in 1669). The lumen shows prominences on its intimal wall corresponding to the external constrictions. Spivak also describes longitudinal corrugation.

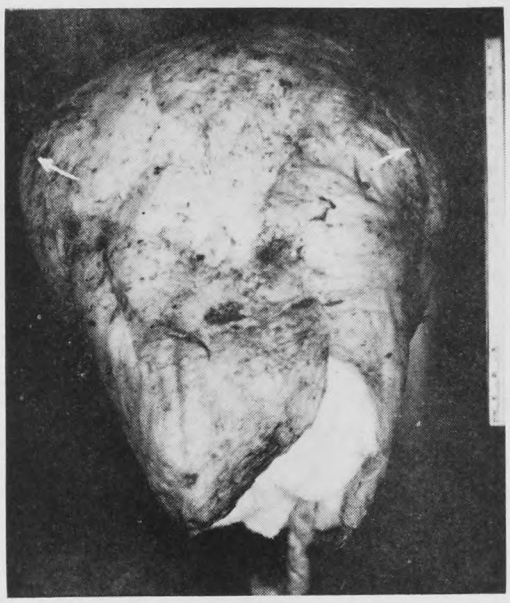


Figure 2

Amniotic sac distension showing cornual bulges (arrows). Sac filled with cotton batten for photography, after prior distension with water.

There is no evidence to show that the folds of the umbilical vessels are present before birth. They may be the result of a closure mechanism at the time of birth.

4. Chorionic Plate

The chorionic plate is that portion of the foetal aspect of the placenta covered directly by chorionic membrane. The vessels show two definite arterial patterns[2], the disperse and magistral types. In the disperse type the two arteries divide dichotomously while the calibre diminishes (Fig. 3). In the magistral type the two umbilical arteries extend almost to the placental margin. The calibre remains almost the same throughout their course. Each terminates as two branches of small size.

The distribution of the arteries may be symmetrical or asymmetrical. In the latter (Fig. 3) one artery may supply two-thirds of the chorionic plate and the other artery the remaining one-third. One artery may supply the periphery of the chorionic plate while the other is distributed to the centre. Normally grossly visible vessels do not extend right to the edge of the placenta. They usually dip into the placenta five or more millimetres before reaching the circumference. This is the best means of determining if a portion of the placenta is retained.

There is usually a communicating branch between the two arteries as they enter the placenta.

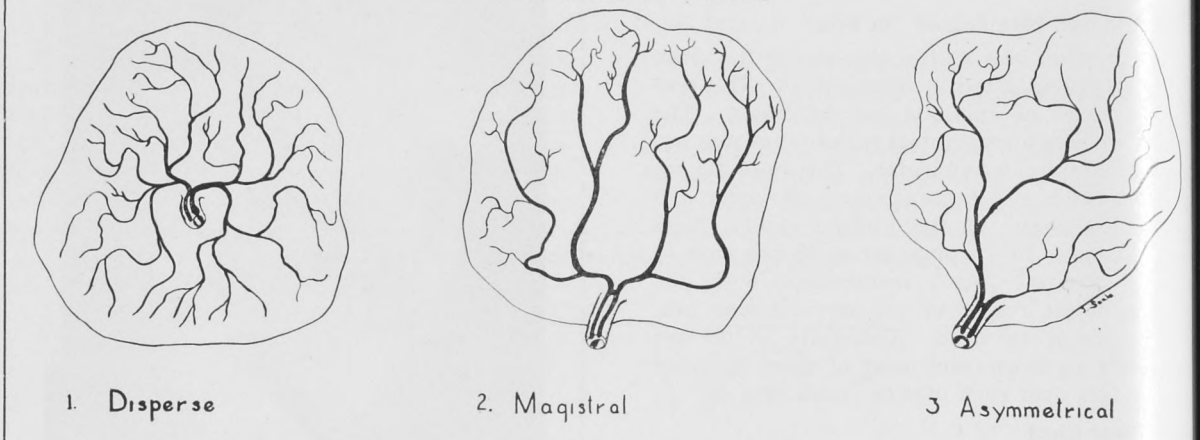
5. Cut Surface

In the immature placenta the cut surface is very pale pink in color, becoming deeper pink and finally a diffuse deep red hue as maturity is reached. No resistance is encountered during section. The maternal aspect may show such signs of senility as calcium plaques.

Summary

The normal anatomy of the born human placenta and its appendages has been described as seen at term birth. The measurements, "in-situ" appearance, the umbilical cord, the chorionic plate and the cut surface are described in sequence.

Figure 3



The transverse anastomosis may be prominent or the two arteries may be fused.

No peripheral anastomoses of the vessels are present[2]. Bacsich and Smout consider them end arteries. They compare the communicating branch to the circle of Willis. If so, the mechanism equalizes the distribution of the blood and regulates the pressure in the placenta.

The veins in the chorionic plate accompany the arteries but are more deeply situated and of larger calibre.

References

1. Adair, F. and H. Theelander, (1925) Am. J. Obst. & Gyn. 10: 172.
2. Bacsich, P. and C. F. V. Smout, (1938) J. Anat. (Lond.) 72: 358.
3. Dees-Mattingly, M., (1936) Am. J. Anat., 59: 485.
4. Dodds, G. S., (1922) Anat. Rec., 24: 287.
5. Hamilton, W. J., J. D. Boyd and H. W. Mossman, (1945) Human Embryology, Heffer, Cambridge
6. Morel, J. and L. Gernez, (1939) Echo. Med. Nord., 10: 401.
7. Potter, Edith and F. Adair, (1948) Fetal and Neonatal Death, University of Chicago Press.
8. Shordania, J., (1929) Z. Anat. Entw. gesch., 89: 696.
9. Spivak, M., (1946) Am. J. Obs. & Gynec., 52: 387.
10. Torpin, R., (1938) J. Obst. & Gynaec. Br. Emp., 45: 993.
11. Torpin, R., (1938) Am. J. Obst. & Gynec., 35: 683.

PAEDIATRICS

Edited by S. Israels, M.D.

Children's Hospital Facilities for Management of Acutely Disturbed Patients

G. M. Stephens, M.D.

The case summaries of two boys are presented to illustrate the benefits of hospitalization for emotionally disturbed children. The first boy, Frank, will be fifteen in November. He has received psychiatric treatment from Dr. Mary McKenty since March, 1947. The following is her summary:

Frank was referred by the Children's Aid Society due to poor adjustment at home and at school.

Family History: Father died in January, 1941, when Frank was 7. His mother went back to work. The earliest record of Frank is a school report in January, 1942, when he was 8. He was reported to have average intelligence, was emotionally immature, very dependent on his mother, lacking in self-reliance, and his reactions were unusually slow. Then nothing was heard of this family until 1946 when the mother died of cancer. Frank, aged 11½, and his older brother went to stay with their maternal grandmother. At the time of mother's funeral Frank was described as unusually quiet, refused to allow anyone to mention the word "death," and told his grandmother that she was lucky as she could cry and he could not. A month following the funeral he was admitted to the Children's Hospital with pneumonia. On the morning of his third day when his temperature had subsided to 99° he began to have hallucinations in which he saw his father and begged the nurses to keep his father away. He appeared to be very frightened. Nurses' notes report spells of irrational behaviour and confused conversation for the next two days. The hospital resident advised psychiatric study following discharge but this was overlooked. Approximately one year later he was referred to the Child Guidance Clinic by the Children's Aid, who had taken guardianship of Frank and his brother although they still stayed with their maternal grandmother. He was reported to be sullen, unco-operative and uncommunicative at home. At school he was a lone wolf, taking very little part in either work or play. Closer study of the home situation revealed a great deal of friction between Frank and his aunt and uncle who also lived with the grandmother. His brother verified many of the episodes which Frank related about the unfair treatment he received from the aunt and uncle. Frank described visual and auditory hallucinations concerning his father at this time. With weekly interviews there was slight improvement for six weeks, but the situation reached a climax when he hit his aunt following a nagging session. He was admitted to the Children's Hospital pending placement in another home. On admission he was confused, frightened, memory was poor, he had difficulty answering simple questions, and he stuttered. Phenobarbital Grs. SS, t.i.d., was prescribed. He gradually relaxed in hospital; nurses reported him to be co-operative at all times. He was discharged to the care of his father's parents who were an elderly couple, speaking Ukrainian while Frank spoke only English. Placement was felt to be only a fair one and unfortunately summer intervened and it was only possible to see Frank twice, though the social worker reported that he seemed to be adjusting well to the paternal grandparents' home. He attended Y.M.C.A. from time to time and went to Y camp that summer. At the camp, under good leadership, no unusual behaviour was noted.

In December, 1947, after seven months at the new home, he was reported to be very demanding, disobedient, sullen, and difficult for the elderly couple to manage. School report was that he showed some improvement in work, though he had dropped all outside activities and was not attending "Y." On interview Frank was emotionally flat, remote, and the hallucinations were again present. He was seen weekly but by March, 1948, the second anniversary of his mother's death, his grandparents could no longer cope with him so he was re-admitted to hospital as a behaviour problem. Once again he soon became co-operative and helpful around the ward, took an interest in the other boys and appeared happy. He remained 37 days. Following a conference with Children's Aid Society he was placed in St. Joseph's Vocational School in April, 1948. This placement began to break down within a week or two. The religious atmosphere appeared to aggravate feelings of guilt which had been previously noted. For instance, he admitted biting or pinching himself every time any profane word entered his mind. Weekly psychiatric interviews revealed increasing emotional disturbance. Speech was hesitant, thinking frequently blocked, he was disoriented regarding the day and date, and he described auditory and visual hallucinations. By May 20, 1948, there was retention of saliva and he presented the typical picture of the catatonic stupor of schizophrenia. Naturally the Vocational School where he boarded became alarmed and immediate removal became necessary when he attacked two staff members at

Paper presented at the Manitoba Medical Association Annual Meeting, on Thursday, September 22, 1949.

the school. At this stage admission to the Psychopathic Hospital was anticipated by the Children's Aid Society. However, in view of his age (14½ at that time) and his previously good adjustments at the Children's Hospital, Dr. Grant agreed to re-admission on May 21, 1948.

Frank remained in the hospital from May until August. The pattern was the same as on previous visits, except that he required Sodium Amytal, Grs. SS, t.i.d., and Medinal, Grs. V, at H.S., for most of his hospital stay. He gradually emerged from his shell, at first conversing with and helping the nurses, and later taking an interest in the other children. At no time did he cause a serious disturbance. After three weeks' stay he was given a job in the laundry which occupied the mornings. He did well there, feeling proud of the responsibility and the prestige. He was allowed to go down to the Y.M.C.A. several times a week, and, as he continued to improve, finally to the two weeks' session at a camp out of town. He returned to the Children's Hospital. The "Y" leaders reported that he was co-operative, entered into the games, and apparently enjoyed himself.

In September, 1948, he was placed in the Knowles School for Boys. This placement was preceded by a conference in which Frank's previous difficulties and his personality needs were frankly discussed. He was not completely sold on this placement as he wished to return to his paternal grandparents. However, with a little pressure he went to Knowles School. Within a month, after the odd fight with some of the other boys, he participated in sports and other activities at this boarding school. The older boys at Knowles School attend the regular Winnipeg Public Schools and Frank, with the help of an understanding teacher, did much better at the same public school that he had previously attended. He was exempted from his June examinations this year. He joined the Army Cadets on his own initiative and was one of a small group selected by the cadet officers to attend a camp this summer. On his return, again on his own initiative, he found a job for the remainder of the summer.

In several conferences on this lad we seemed to have at least two "sixty-four dollar questions." The first, would he have responded as quickly to the adult environment of a mental hospital as he did at the Children's Hospital? The second question, is this boasted-about improvement merely a superficial one covering a deep-seated malignant schizophrenic process? Only time will give us the second answer, but a happening he reported to Dr. McKenty around "Sadie Hawkins' Day" last November raised my hopes very considerably that the answer may be favorable to Frank, providing he has a fair share of the breaks from now on. Coinciding with a marked improvement in his personal appearance, Frank confessed to Dr. McKenty that there was a nice quiet girl in his school who was too shy to snatch Frank or any other boy for the Sadie Hawkins' dance so he asked her, to their apparent mutual enjoyment.

The second boy, Gerald, aged 12, received intensive treatment from Dr. Betty McKim for two months in the fall of 1948.

When Gerald was six years old the school attendance officer learned that he and his older brother were stealing and were coming to school dirty and poorly clothed. The Children's Aid Society was asked to investigate but the social worker was soundly rebuffed by the mother. Mother was given an appointment at the Child Guidance Clinic but failed to keep it.

Gerald continued to steal, play truant, and run away from home occasionally during the next three years. The Children's Aid worker tried to keep in touch with the family but received no co-operation. Gerald's behaviour was not such as to afford grounds for apprehension by court order under existing Child Welfare laws. When Gerald was nine his mother did give some information to the worker, though she still seemed resentful toward the agency. She indicated that her marriage had never been very satisfactory and said her husband interfered with her discipline of the children. Gerald was the second of four boys. He was conceived four months after the first boy was born and was not wanted. He had caused trouble ever since the age of two, when he began to wander all over and had to be brought home by the police. Mother blamed Gerald for getting the other children into trouble. The worker found the father to be a thin, worried looking man with nervous mannerisms.

The worker persuaded Gerald's mother to take him to the Child Guidance Clinic to see me in May, 1947. Mother told me that Gerald's trouble might be due to a blood transfusion received for a burn in infancy. The donor was, in her words, "a fellow who wants his own way just like Gerald does." She complained that Gerald soiled himself but said he could control this if he wanted to. She was ignorant, superstitious, and had many complaints about her own health. I felt she was neurotic, unstable and not too bright, and that the child's symptoms were chiefly due to her rejection of him, which included extremely unfavorable comparison with her other children.

I advised the mother to have Gerald attend Children's Hospital, O.P.D., but she failed to do this. I suggested that mother seek medical advice for her own complaints. We asked the Children's Aid worker to make further attempts to help the parents, and if this failed that the child be placed away from home. The parents continued to avoid the worker's visits and Gerald felt that the worker was trying to take him away from home. He would run away whenever she called. Playing

truant from school became so frequent in the fall of 1947 that the Juvenile Court Judge granted the C.A.S. guardianship for two years. Gerald was very frightened of placement but a social worker spent a great deal of time with him to gain his confidence and succeeded in getting him settled in St. Joseph's Vocational School. He did well there for several months. Then the worker, through lack of time, was not able to give him as much attention as he needed. At the same time the mother upset him on her visits by telling him that he could leave, so he ran away. After that he did not want to return to St. Joseph's and each time he was returned he ran away. A foster home placement was attempted in September, 1948, but he ran away within a few hours. He was then taken to the Juvenile Court Detention Home. Dr. McKim saw him at the Child Guidance Clinic and found him to be still clinging to the idea that his parents wanted him. When leaving the Clinic he got away from the Juvenile Court probation officer. He had lost confidence in the Children's Aid worker because of his parents' influence. It was felt that he needed psychiatric treatment and time to develop some confidence in the worker before any long term placement could be successful. If placed in a foster home or school he would undoubtedly run away again and court authorities were unwilling to keep him in detention for more than a few days since recreational facilities are lacking there. Commitment to an institution for delinquents was considered unwise because of his age (11) and the nature of his problem. Children's Hospital was the only institution where running away could be made difficult and which offered a warm, pleasant atmosphere with recreational and school facilities. The case was discussed with the hospital staff and they agreed to admit him.

On arrival at the hospital he immediately darted from the car, was foot loose for a day or so, was then returned to the Detention Home until another hospital bed became available. On the second occasion he was carried into the hospital and required intravenous sodium pentothal to be undressed. When he came to on the ward he didn't accept the interne's victory with good grace. In frequent psychiatric interviews he became more friendly with the psychiatrist and gradually regarded the hospital staff and the Children's Aid workers as people who would help him. He received a lot of attention from several of the nurses and became quite attached to them. He gradually accepted the fact that his parents had rejected him and was able to face this due to the understanding he received from other adults. He no longer wanted to run home and gradually accepted the idea of a foster home. A young couple on a farm about 20 miles from Winnipeg agreed to take him and visited him twice while he was still in the hospital. The worker then took him to their home and he has been there for ten months. A few weeks after his arrival the foster father hurt Gerald's feelings by giving him an amateurish hair cut. Gerald started to run away but the foster father caught him after a mile's chase. By this time the foster mother had become attached to Gerald and was weeping when she informed the foster father that Gerald had eloped. Apparently the foster father explained to Gerald that one of the reasons for the moderate whipping which Gerald got was because he had worried his foster mother so much by running away. The foster parents claim that Gerald was amazed by anyone showing that much concern for him. They and the social worker felt that this incident was a turning point in his satisfactory adjustment since that time.

In two months from now the Children's Aid guardianship will expire and the judge will have to decide whether or not he should be returned to his parents. Since Gerald went to his foster home a younger brother has had to be apprehended by the Children's Aid because of truancy and the older brother has been charged with delinquency and sent to the Portage School for Boys (Reform School).

We refrained from too much psychiatric jargon in these summaries in the hope that you could get a clearer picture about the etiology, pathology and therapeutic processes which were at work in these particular illnesses. We try to avoid too much diagnostic pigeonholing as the latter seems to narrow the concept of the total child. Besides, it makes us uncomfortable to give them psychiatric tags because most of us see in our own children some very similar behaviour patterns, differing more in degree than in their fundamental nature. We also try to avoid, what Gesell calls, erudite rationalizations in our own explanations about childhood development. On the other hand, we do feel it is important for anyone dealing with children to realize that a child's basic needs for healthy development extend beyond the area of calories, laxatives and a rigid routine. If you are interested in reading about the scope of these basic needs, I would suggest that you consult the writings of three men, all of them primarily pediatricians, viz., Spock, Aldrich and Gesell. Their writings are based on salutary clinical experiences. The following books are written for parents, teachers, nurses, etc.: "Babies Are Human Beings,"[1] written by Aldrich; Gesell's two books, "Infant and Child in the Culture of Today"[2] and "The Child From Five to Ten"[3]; and Spock's "Baby and Child Care."[4]

In view of the contributions pediatricians have made to the understanding of childhood development, those of us in psychiatry feel particularly

honored that the Children's Hospital opened its doors to us and to our colleagues in psychology and social work. In addition to the social workers, psychologists, City and Suburban Public Health nurses, and the usual hospital staff, the Junior League of Winnipeg has sponsored the training, and now the employment, of a graduate nurse as an "Activity Supervisor." She supervises voluntary workers in the hospital, arranges the play periods for the children, and interprets to the pupil nurses the importance of counteracting the normal reactions of fear and loneliness which so often accompany illness or injury. Her work is directed to all hospitalized patients who are not critically ill. We have hopes that as this work expands the discharged patients will be much readier to get back into normal childhood circulation, and that there will be fewer who remain for emotional reasons, too delicate to get into healthy circulation. The work of a full time teacher employed by the Winnipeg Public School Board makes it much easier for the discharged patient to return to his regular school programme.

You will note that the facilities helping these boys were the personal services of a staff which included psychiatrists and men in the hospital laundry. In a new hospital with less overcrowding and more recreational space, we hope a larger number of children will receive greater benefits with much less wear and tear on the regular hospital staff.

Fairly disturbed children can often be treated in the out-patient psychiatric clinic. This service is also a co-operative enterprise between the Hospital, City Health Department and Winnipeg Public School Board. Children from all parts of the Province are referred by private Practitioners, Public Health Nurses and Welfare Agencies. You can see that all these disciplines cluttering up a Children's Hospital add greatly to the confusion and cost to the hospital and to the municipal authorities. In my opinion these high per capita costs can only be justified if children at large receive tangible though indirect benefits. Clinical case conferences with medical students, nurses, social workers, teachers, and any other personnel who have much contact with children, should give these personnel a better understanding of children. We like to think that these efforts will do something towards more comprehensive nursing and medical practices in the future. The Commonwealth Fund arranged a three-day conference in Pennsylvania to discuss Pediatrics and The Emotional Needs of the Child. They introduce their report[5] of this conference by this paragraph:

"Of all the problems that perplex the thoughtful physician at the moment, none is more difficult or more important than the problem of relating the whole of medicine to its parts. We are at or near the climax of a wave of specialism which has produced spectacular gains at a definite cost, the cost being a significant and sometimes tragic diminution in the capacity of the physician to meet the human need of the patient, that is, to practice medicine comprehensively. One specialty of medicine in which a considerable measure of comprehensive thinking has been preserved is pediatrics, but even here specialism, as indicated by too complete a preoccupation with the physical aspects of the child, has gone so far that leaders in the profession have begun to call it in question."

During this past year I watched residents and other young physicians treating emotionally disturbed children and the equally disturbed mothers. The improvement noted in most of their patients surprised and intrigued them. The procedures such as listening to an over-anxious mother, or helping a little girl play house, probably seemed quite foreign to their concept of therapeutics. Even a few clinical experiences of this sort are much more enlightening than any amount of reading and lectures about psychopathology and childhood development. I hope that these clinical opportunities will soon become obligatory in undergraduate medical training.

Very few graduates will have no professional contact with children and mothers and most of these few will acquire some children of their own. The general practitioner and the pediatrician have more opportunities and potential prestige in the field of child care than an army of social workers, psychologists and psychiatrists. Possibly the latter group moved in because there were too few Spocks, Aldrichs and regular family doctors practicing comprehensive medicine.

References

1. Aldrich, G. Anderson and Mary M., Babies Are Human Beings, MacMillan Co., 1944.
2. Gesell, Arnold and Ilg, Francis L., Infant and Child in the Culture of Today, Harper, 1943.
3. Gesell, Arnold and Ilg, Francis L., The Child from Five to Ten, Harper, 1946.
4. Spock, Benjamin, The Pocket Book of Baby and Child Care, Pocket Books, Inc., New York, 1946.
5. Pediatrics and the Emotional Needs of the Child, The Commonwealth Fund, New York, 1948.

General Practitioners' Association of Manitoba

The American Academy of General Practice & Medical Practice Today

U. R. Bryner, M.D.

413 Medical Arts Bldg., Salt Lake City, Utah

Dr. Gowron, members of the General Practitioners Association of Manitoba and friends: It is more than just a pleasure for me to be here with you tonight. Indeed it is like a homecoming. The most impressionable and formative years of my life were spent in western Canada. At the age of five years, following the death of my father, my mother took her small, young family and moved from Nevada to Alberta to make a home near her brother. There I lived from the age of five years to the age of twenty-four. Attended grade school, high school, normal college and taught high school for three years.

After making up my mind to study medicine it was a toss-up as to where to go. Although we had lived in Alberta for nineteen years, my mother had never become a naturalized Canadian citizen, and expressed a desire that I go back south to attend Medical school. Thus I returned to the United States and entered the University of Utah in 1926, then transferred to the University of Pennsylvania where I graduated from their school of medicine in 1932 and returned to Utah again for internship and further training before beginning general practice in Salt Lake City, Utah.

As a boy I learned to love Canada and the British Commonwealth and all it stood for. I assure you I can still stand up and sing "God Save the King" and "The Maple Leaf Forever" with as much enthusiasm as can be displayed by anyone present here tonight.

Our profession is surely one that is not separated or bound by national boundaries. Your great advances in medicine are available to us just as our advances are available to you. This 49th parallel of latitude certainly does not form any barrier to keep medical knowledge from going back and forth. The medical profession, the world over, has one purpose. Let's hope the World Medical Association can bring all medicine and medical practitioners the world over, closer together.

My last and only previous visit to Winnipeg was during the summer of 1927. I had been out through North Dakota selling Utah manufactured woollen goods to pay my way through medical school. My partner and I drove up here over a week-end from Grand Forks, N.D. The one thing I well remember about that short trip was visiting the Government buildings and listening to the Right Honorable Stanley Baldwin give a public address from the balcony of the Government Building. Little did I then think that, twenty-two years later, I would be coming to the same city again, this time to bring you a message and a goodwill hand-shake. I assure you I am very humble in this task of greeting you as a representative of the American Academy of General Practice. It has been one of the great privileges of my life to serve as an officer of the American Academy of General Practice. I am indeed deeply grateful for the honor and privilege of being associated so closely with the fine men who make up the officers and board of directors. I bring to the General Practice Association of Manitoba, the hearty hand-clasp of good fellowship from every officer and member of the Academy.

Provision is made in chapter III, section I of the by-laws of the American Academy of General Practice, for the admission of chapters from any state or territory of the United States or Province of Canada. I sincerely hope that in the not too distant future, a chapter of the Academy will be formed in every Canadian Province beginning here in Manitoba.

At this time I believe a short history of the formation and progress of the Academy is in order. During the American Medical Association convention in San Francisco in 1946, a group of general practitioners met following one of the scientific sessions of the general practice section of the American Medical Association. This small group made preliminary plans to form an organization of General Practitioners at the time of the Centennial Session of the American Medical Association meeting in Atlantic City in June, 1947. Committees were appointed and an enormous amount of work was done during the 12-month interval. One committee drew up a constitution and by-laws. Another committee contacted every county medical society in the United States, telling these organizations of plans to organize general practitioners into a national group in June of 1947.

On June 10th, 1947 . . . just 100 years after the organization of the American Medical Association . . . about 200 general practitioners from every section of the country met in the Claridge Hotel in Atlantic City and organized the American Academy of General Practice. A constitution was adopted and officers were elected.

Dr. Paul A. Davis, of Akron, Ohio, was elected the first President with Dr. E. C. Texter, of Detroit, Vice-President and Dr. Stanley R. Truman, of Oakland, California, Secretary. These men, as time has proven, were really inspired for their

An address delivered to the General Practitioners Association of Manitoba at Winnipeg, September 20, 1949.

work. The Treasurer went back to Utah, following the organization meeting, with a little over $5,000 in checks collected as initiation fees and annual dues.

General practitioners, although comprising about 80% of all practicing physicians had never before had a national organization of their own. They had never had a voice in the fold of organized medicine. Previously they had seemed content to let the numerous specialty group organizations have all the say in these fields.

Even the American Medical Association's officers and board of trustees were mostly drawn from these specialty groups. And very few members of the house of delegates were general practitioners. Thus the small 20% did most all of the work in organized medicine.

Following the organization of the American Academy of General Practice . . . with no special effort or pressure . . . applications poured in until the Secretary and the Treasurer were literally deluged with applications and checks and it was found absolutely necessary to find a competent executive Secretary and to establish a headquarters office. No one but the best would suffice and after weeks of research we all decided Mac F. Cahal was that man. Although Mac was then comfortably established in Chicago as Executive Secretary of the American College of Roentgenology, he gladly accepted the offer of our newly formed organization. He considered it a great challenge and still does. Mac is well educated, an attorney, a good speaker, a deep thinker, an honest, fair, impartial man with great vision and foresight and able to judge qualities in people. He is a prodigious worker. He has had a vast experience in the field of medical organization. Mac has established a fine headquarters office in Kansas City and has surrounded himself with very capable assistants, numbering nineteen at the present time.

In two years our numbers have increased to about 12,000 members. We have chartered chapters in 42 states and the District of Columbia. We had our first annual meeting in Cincinnati, Ohio, last March. We anticipated a total attendance of 1,000 to 1,500 and final figures showed a total registration of 3,499.

Our second annual meeting will be held in St. Louis, Mo., February 20th-23rd, 1950. You are all very cordially invited to attend these meetings. Some 25 or more nationally prominent speakers will be on the programme. Literature sent to every doctor in the United States telling of the plans for this 1950 meeting in St. Louis has brought 5,374 replies to date, most of these contain applications for membership. So you see our numbers are rapidly increasing.

Our membership committee, our programme committee, our hospital committee, our education committee and our public relations committee are all actively working and accomplishing a great work.

Our publications committee has been working overtime lately. Very satisfactory progress has been made to date and we hope to publish our first monthly issue of a national magazine next April. Dr. F. Kenneth Albrecht has been secured as Editor. He is a man of great ability and enthusiasm. He has published several medical books and has also been editor of one of our popular medical journals. The publishing of a new medical journal is an enormous task but will do much for the Academy, especially for those who do the work.

Many of you have in your minds questions as to what is the American Academy of General Practice? What are the requirements for membership, etc.? I would like to answer here a few of the questions most often asked.

1. What is the American Academy of General Practice?

The American Academy of General Practice is a national association of general practitioners of medicine and surgery.

2. What are the requirements for membership?

To be eligible for membership, a candidate must be a graduate of an approved medical school, a member of his county medical society, licensed to practice medicine and surgery in the state or province of his residency, of high moral and ethical character. He must have shown interest in continuing his medical advancement by engaging in post-graduate education.

3. What is meant by the term "general practitioner?"

A general practitioner is a licensed physician and surgeon who holds the degree of an M.D. and who does not limit his practice exclusively to a particular field of medicine or surgery.

4. How much post-graduate training is required of candidates for membership?

The by-laws of the Academy require that a candidate for membership shall have been engaged in the general practice of medicine for at least three years preceding the date of his application. During this period he must have shown interest in continuing his medical advancement by engaging in some post-graduate educational activities. Post-graduate activities include attendance at hospital staff meetings, county, state, provincial and national society meetings, refresher courses and formal courses, or rotating residencies conducted by approved institutions.

5. What must a member do to retain his membership?

All active memberships terminate at the end of three years. To be eligible for continued membership, a member must have spent a minimum of 150 hours during this three-year period in post-graduate training of a nature acceptable to the membership committee. Any of the activities

mentioned above will count toward fulfillment of the 150-hour requirement during a three-year period.

6. What are the objectives of the Academy?

The basic philosophy of the Academy is: Improved standards and quality in general practice among the general practitioners who render more than 80% of the medical care furnished in this country today will react to the great benefit of all the public and all the medical profession.

The objects and purposes of the Academy as set forth in its constitution are as follows:

(a) To promote and maintain high standards of the general practice of medicine and surgery;

(b) To encourage and assist young men and women in preparing, qualifying and establishing themselves in general practice;

(c) To preserve the right of the general practitioner to engage in medical and surgical procedures for which he is qualified by training and experience;

(d) To assist in providing post-graduate study courses for general practitioners, and to encourage practicing physicians and surgeons in such training;

(e) To advance medical science and private and public health.

7. Why was the Academy formed?

The American Academy of General Practice resulted from a spontaneous movement among groups of general practitioners in a number of states who were convinced that progress and advancement in the general practice of medicine and surgery was basic to the welfare of the people of America and the medical profession.

Years ago the various groups of specialists established standards and undertook programmes for the elevation of standards and quality in specialist practice. The specialists established and enforced their own standards; no outside group could do this for them. The same is true in general practice. The trend toward over specialization is a matter of serious concern among many leaders of the profession and among medical educators. The best way to counteract this trend is to make better general practitioners who, through self-improvement, can command the respect of the public and a place of esteem in the profession. To improve the quality of general practice it is necessary that increased emphasis be placed on broad clinical training in the medical school curriculum. It is also necessary that facilities for post-graduate education for general practitioners be greatly expanded. These goals represent the chief aims of the Academy.

8. Does the Academy advocate that all general practitioners be permitted to practice medicine and perform surgery in all hospitals?

No. The Academy recommends that proper requirements be maintained for staff privileges in all hospitals. Hospital privileges should be extended to all licensed physicians on the basis of competency. The Academy will do all in its power to assure that every competent general practitioner be privileged to hospitalize any of his patients who require hospital facilities. The Academy endorses official actions taken by the American Medical Association, the American Board of Surgery and other interested organizations opposing any hospital regulations which confine staff membership, or the right to perform certain medical and surgical procedures, to specialists who have been certified by the respective specialist boards.

9. What is the relationship between the Academy and the American Medical Association?

The Academy recognizes the American Medical Association as the parent organization of the medical profession in America. Its aim is to work in co-operation and close harmony with the American Medical Association. Membership in the American Medical Association is a pre-requisite for membership in the Academy, and any member of the Academy whose membership in the American Medical Association is terminated will lose his right to maintain his membership in the Academy. In its endeavors to improve the quality of general medical and surgical practice in America, the Academy intends to work closely with the Council on Medical Education and Hospitals, of the American Medical Association, the Committee on Rural Health and the Council on Medical Service, as well as other councils and bureaus of the American Medical Association.

10. Does the Academy propose to establish a certifying board in general practice?

No. In years to come a certifying board of general practitioners to examine candidates engaged in general practice may be feasible, but such is not the present intention of the Academy.

11. What will be the relationship between the Academy and the specialty boards?

The Academy intends to carry on its programme in co-operation with the specialty boards wherever such co-operation is indicated as desirable. The Academy does not intend to duplicate the activities of the specialty boards of the American Medical Association, of the American Hospital Association, or any other national medical organization.

12. How does the Academy expect to increase the quality and raise the standards of general practice in America?

In the same way as the specialty societies have raised the standards and increased the quality of specialists' practice in the country. The Academy intends first to encourage general practitioners to pursue graduate study by attendance at their county, state and national society meetings, their hospital staff meetings, clinical pathological conferences, and special courses. Furthermore it

hopes to raise the general level of the quality of general practice in the country by establishing a standard toward which general practitioners will be expected to strive. To achieve this standard they must keep up-to-date and continue their medical education each year.

Also, the Academy, through co-operative efforts with the American Medical Association and the American Association of Medical Colleges expects to improve the teaching of the general practice of medicine and surgery in medical schools. By improving the quality of medical teaching and by stimulating post-graduate courses and extension courses, to be conducted by medical schools, the Academy hopes to raise the general level of the quality of medical care throughout the country, including rural areas.

13. Is the Academy a "political" organization?

No. The Academy will naturally lend its support to other medical organizations which oppose political or socialized medicine, but such activities are not among the principal objectives of the Academy. The founders of the Academy have recognized the fact that the surest way to overcome efforts to socialize medicine is to re-establish the general practitioner . . . the family doctor . . . as the keystone of the health professions, occupying his rightful place in the citadel of medicine, and enjoying the respect and confidence of his patients.

Every general practitioner should be allowed to do hospital work and care for his own patients, in the hospital, to the extent of his own training and ability.

The American Academy of General Practice is not a pressure group. It is not going to demand recognition of its own members merely because its numbers are large. It is going to first stimulate its own members to get more training, then due to their abilities, will demand and get due recognition in hospitals throughout the country.

General practice has cares, anxieties and responsibilities that go along with it. Some of these anxieties, I feel, are due to the trend of the time in which we live . . . trends which are creating conditions that are strange to our accepted ways of thinking and acting, in which the so-called laws of economics are ceasing to be laws, which indicates that society has grown weary of convention and is avidly seeking change, whether it be good or bad.

Advances in the medical field are constantly broadening the horizon of medical practice and enabling the practicing physician to increase the measure of his effectiveness in alleviating human ills. But standing as a hindrance athwart the path of scientific advances in the field of medicine, is the cost of bringing these advances to the patients who need them. In other words, in the economics of medical practice is found the challenge to our future progress and security. Dr. Paul R. Hawley, in a recent letter published in the Michigan Medical Society Journal, clearly sets forth the position of the practicing physician in these words:

"The time is past, if indeed it ever existed, when the responsibility of the physician is limited to providing medical care. He must now offer a solution to the economic problems of medical care. He alone can do this without revolutionizing the pattern of medical practice."

The need for effective action in this battle of economics is pressing indeed. How pressing is demonstrated by the urgency with which our government bureaucrats and socializers with their ever-present promises of something for nothing are injecting themselves into the medical field. Unfortunately on the subject of medical care the government bureaucrats and socializers do have something to talk about. For it cannot be denied that the cost of the finest medical care today exceeds the ability of the average person to pay for it. The problem posed is dramatic, vital and is one that must be solved. Of what importance is it to the medical profession whether the government does or does not enter the field of medical care? Primarily this: It injects into the time-honored confidential relationship which has existed between the practicing physician and his patient, a third party, a party who controls the purse strings and over whom the doctor can exercise no control, yet from whom the doctor can only take orders. To any thinking member of the profession, such a situation would be intolerable. It would inevitably mark the descent of the general practitioner from the respected position he has always held as a member of an honored profession, to that of a salaried employee of the government. It is frequently argued that government medicine would not necessarily mean loss of professional integrity by the medical profession. It would be true, I am sure, that those of us who have practiced under the present regime would for a time be able to preserve a few of the traditions of the profession. For, of course, the transition would not be immediate. But what of the younger men who enter the field of practice in medicine under government control and never know anything but that type of practice? What traditions can they know? Around what conception of medical practice will their ideals and attitudes be built? Those of government intervention and control without doubt. And once medicine has been established in the minds of future practitioners as a salaried job, professional standing would be forever lost.

In socialized countries physicians have little time for study and research. They have to see too many patients in the course of each day. Adequate care under this system is more lacking than under our own.

The United States and Canada are the only countries in the world which spend adequate amounts on medical research.

The socializers in the United States, sensing an opportunity for the exploitation which will result in great benefits to themselves, ignore the facts that argue for the superiority of our present regime, and falsely stress the statistics of the rejections of the last war, emphasizing the deplorable state of the nation's health, contending that adequate medical care is possible only under a compulsory system.

Much has been said in the defense of the profession and indeed much more can be said. But we must not overlook the shortcomings within our own ranks. And, while there is the matter of legitimate increase in the cost of medical care today, what is even more important to the future well-being of our profession is the ever present problem of exorbitant fees charged by certain doctors. . . . I hope not by general practitioners.

More than ever before, it is now imperative that we keep before us the important fact that we undertake the practice of medicine to serve humanity, and alleviate its suffering, and that the members of the profession are not to use their practice primarily as a means of the acquisition of wealth. The step from the concept of the medical practitioner as an angel of mercy, alleviating the pains and sickness of mankind to the concept of the practitioner as a vulture preying upon the ills of humanity and growing wealthy in the process, is a short one. It is up to the profession to see to it that the conduct of its members is such that society will never adopt the second concept.

Too many of the members of the profession have forgotten that the era of specialization which has brought about a partial disappearance of the family physician has deprived the profession of much that endeared it to the heart of the people.

The profession is doing a great deal to meet the problems presented on the economic side of medicine. Vastly more remains to be done. And an alert and conscientious general practitioner can help immeasurably in achieving these goals. Each and every one of us can see to it that the efforts of our professional organizations are not rendered valueless by constantly keeping in mind that a satisfied patient . . . one who feels that his needs have been administered to well and at a fee that he can afford to pay . . . is a friend of the profession. On the other hand, we must never forget that a patient who feels that he has been subjected to an inferior quality of medical care is an enemy to the profession, and a dangerous one.

A compulsory system will be the price we pay for ignoring the fundamental principle of unselfish, devoted service . . . a basic law of public relations. If all our members could be depended on to make every patient feel that he had been well taken care of, the threat of socialized medicine would disappear over night.

The medical profession recognizes the fact that a problem exists in this field of good medical care to all. Organized medicine must continue to work on the problem and come up with a plan that will really fulfil the needs of the people and yet not lower the quality of medical care. I firmly believe that the cost of medical care can be reduced, the availability of medical care increased, and the quality of medical care improved, if the people will accept the policy of each person or family turning to a general practitioner as his family doctor, medical guide and health advisor.

While recognizing the need for highly skilled specialists in every field of medicine, the people nevertheless want general practitioners, who will fill the roll of the time honored family physician.

Many wise and discerning individuals, in and out of the profession, feel that one of the great deficiencies of present day medicine is that too many specialists and too few good general practitioners are being produced. The organization of societies like your own and the American Academy of General Practice, which by their very existence will tend to elevate the standards of general practice and to increase the esteem in which the family doctor is held both within and without the profession, will do much to solve this problem.

Measure as we may the progress of the world, materially in the advantages of steam and electricity and other mechanical appliances; sociologically in the great improvements in the conditions of life; intellectually in the diffusion of education; morally in a possibly higher standard of ethics . . . there is no one measure that can compare with the decrease in physical suffering in man, woman and child, when stricken by disease or accident. This is the one fact of supreme personal import to every one of us. This is the greatest gift of the past century to man.

For better or for worse there are few occupations of a more satisfying character than the practice of medicine, if a man can but get oriented and bring to it the philosophy of honest work, the philosophy that insists that we are here, not to get all we can out of life about us, but to see how much we can add to it. We are in the most comprehensive, least monotonous and most stimulating department in the practice of medicine. Let us make "general practice" the most important specialty in the field.

ANAESTHESIOLOGY

Edited by R. G. Whitehead, M.D.

An Easy Pilgrimage in 1949

D. C. Aikenhead, M.D.

Whan that Aprille with his shoures sote (sweet)
The droghte of Marche hath perced to the rote,
Than longen folk to goon on pilgrimages
And specially, from every shires ende
Of Engelond, to Caunterbury they wende.
—Canterbury Tales.

Six centuries have passed since Chaucer wrote these famous lines. Throughout the Northern Hemisphere as the snow disappears most Anglo-Saxons "longen" to go somewhere. My wife and I were agreed that "it is later than you think" and keeping this in mind we found ourselves in England on April 19th, Easter Monday. We left Winnipeg with the snow in the fence corners. One week later we were amazed at the profusion of flowers and grass, of such a greenness that it must be seen to be believed.

Oh, to be in England
Now that April's there.

The Anaesthetic Editor of the Bulletin has suggested that a brief review of some of the centres visited might be of some small interest to its subscribers. Let us commence our pilgrimage at Oxford. Oxford overwhelms one. King Charles I held parliament in the hall of Christ Church College. The martyrs' Memorial recalls the sacrifice of Cranmer, Ridley and Latimer. A visit to either Magdalen or Corpus Christi College is worth the trip to England. Jostling medieval Oxford is the modern Morris motor car works at Cowley, supposedly the largest in England. We called at 13 Norham Garden where for so many years Sir William and Lady Osler kept open house to a host of friends. Osler was unknown, even the attendant at the Bodleian library having to consult an old directory to find that Osler was once a curator of the Bodleian. Sic transit gloria mundi. I could write indefinitely of historical Oxford but perhaps I should get on with my clinical impressions.

In the late 1930's Lord Nuffield provided sufficient funds for the establishment of a Chair of Anaesthesia in the University of Oxford. Professor R. R. Macintosh is Director of the Department at the Radcliffe Infirmary and Professor of Anaesthetics in the University. He is the author of "Essentials of General Anaesthesia," "Physics for the Anaesthetist," besides many scientific papers upon the various aspects of anaesthesia. The major portion of the clinical work is performed at the Radcliffe Infirmary. This year they were celebrating the bicentenary of Radcliffe Amongst other exhibits I noted the famous gold headed cane carried by Radcliffe, scientific papers written by Radcliffe and a medical prescription for Queen Anne.

The surgical slates at the Radcliffe run throughout the day. During one week one may see a wide variety of surgery. The anaesthetic agents most commonly used are pentothal, nitrous oxide and curare. Probably economics enter into the limited use of cyclopropane. Most laparotomies are intubated with a tracheal tube with a balloon on the distal end. The inflating catheter to the balloon plus the balloon are incorporated into the side wall of the tracheal catheter. The whole ensemble is neat. These catheters are sold by the Medical and Industrial Equipment Ltd. 12 New Cavendish St., London, W.I. It follows when the balloon is inflated gases cannot escape around the side of the catheter. I enquired about post-operative sore throats. They were of the opinion that any possible throat irritation following operation was a minor difficulty compared to the advantages it gave the anaesthetist in controlling the airway of the patient during the operation. They use curare (d-tubocurare cl.) in doses 20 cc's, 60 mgs., 400 units, for a major laparotomy during a period of two hours. During the operation the respiration required manual assistance. At all times tissue oxygenation appeared adequate. Atropin sulph. gr. 1/100 and Prostigmin 5 mgs. were given I.V. at the conclusion of the operation. In most instances the use of these drugs gave almost dramatic results. From a mass of tissue where the heart was the only voluntary source of movement, within a minute the head would move without assistance, the eyeballs would oscillate and a few sluggish throat reflexes become evident. It was obvious that the patient was in a better condition to return to the ward following the administration of the analeptic.

I.V. fluids were not used as freely as in America. Patients whose fluid balance was normal and haemoglobin levels over 75% rarely received I.V. fluids during the operation unless this balance was markedly disturbed by some surgical incident. I noticed throughout England that each time an I.V. was given a fresh venipuncture was made. I prefer to have the I.V. fluids start before surgery, and I.V. drugs can easily be put through the rubber I.V. tubing. One anaesthetist was very fond of the Gordh needle (Anaesthesiology, January, 1945, page 258). This needle has a rubber diaphragm at the hub. Through this diaphragm I.V. fluids or medication may be given. A favorite site for this needle was the external jugular vein. In this situation

the needle was out of the way of the surgical assistants but a venipuncture with a leak into the tissues appeared as a blast injury next morning.

The rate of flow of anaesthetic gases is shown by the Rotameter. This conical bobbin floats and rotates upon the upward stream of gases. It would appear to be equal or superior to the devices we use in this country for the measurement of the flow of gases used in anaesthesia. Anaesthetic units were of British manufacture, somewhat larger in size than we use with the four anaesthetic gases in cylinders at the side of the machine. I think the use of to and fro carbon dioxide absorbers exceeded that of circle filters. Before returning the patient to the ward a most careful pharyngeal toilette was undertaken. The anaesthetist, during the next 72 hours, watched the patient carefully for any sign of atelectasis. They were conservative in the use of the bronchoscope following operations but they did not hesitate to use a bronchoscope if by its use a bronchial plug might be aspirated. I did not see chloroform used. Ethyl ether is used mainly for instructing medical men in its use where skilled aid is not available. I believe an inexperienced person can do less harm to a patient with ethyl ether than the same individual attempting to use a machine of which he knows little and anaesthetic drugs even less.

The Macintosh laryngoscope is the one most commonly used for exposing the larynx. A most satisfactory type of suction for general use is provided by a 220 cu. ft. oxygen tank with an injector connected with metal tubing. A foot pedal controls the flow of oxygen. (Physics for the Anaesthetist, page 177). One may use the oxygen from this tank in the usual manner. By simply depressing the foot pedal at the base of the oxygen carriage strong, efficient suction is instantly available.

Radcliffe has a splendid obstetrical unit. Upon arrival at the hospital the patient leaves all her clothes in a locker before having a shower and special care of the hair. Sterile hospital clothing is issued before admission to the ward.

Wide choices in the self administration of nitrous oxide are available. A number of types I had never before seen. The most popular were the Minnitt Inhaler and a Swedish machine with a very accurate type of gas flow. During the World War II the Air Force had a small machine for the administration of chloroform. This device kept the percentage of chloroform vapor from ¼ to 2%. This machine has been modified so that one can use trilene vapor in varying percentages. One morning I watched for an hour this type of apparatus using trilene for obstetrical analgesia. The analgesia was satisfactory though the patient required more attention than most large hospitals are prepared to give for such work. Those who have used trilene extensively believe that the field is in analgesia rather than muscular relaxation.

I saw the new obstetrical self analgesy for trilene for the use of midwives. If one can believe current talk Mr. Aneurin Bevan has high hopes that this analgesy will aid his political fortunes in the next general election in Great Britain. The unit is about 4 ins. by 6 ins., of stainless steel and supposed to be fool proof. It is so constructed that unless the midwife deliberately opens the filler cap trilene cannot escape. Should trilene lodge upon Madame's dressing table the fine finish would be injured. So much preliminary work has been done on this unit that should it not meet with popular support no one can truthfully say the device was introduced without a trial.

The senior resident in obstetrics was of the opinion that the contractions of the uterus plus the passage of the foetus through the birth canal aid in the expulsion of the amniotic fluid and other debris from the inferior and smaller bronchi to the larger and upper portion of the bronchi. In Caesarean sections if this theory is tenable the child will require more suction of the upper respiratory tract than a normal birth. The resident stated that all Caesarean babies who showed difficulty or hesitancy in breathing after delivery should have the larynx exposed and bronchial suction. He reported the removal of a large "Y" clot by means of a laryngoscope and bronchial suction following a Caesarean Section to have had almost a magical effect upon the baby's respiration.

One could not leave Oxford without mentioning the Oxford Vaporizer. During World War II this instrument had a wide use. Many anaesthetists are agreed that in this machine we have the best system of control for the even and steady administration of ethyl ether. One would expect to find the Vaporizer in daily use where it was developed. This assumption is correct. However, I did not find the Vaporizer played so prominent a part in the Anaesthesists armamentarium at other centres in England.

I spent a delightful morning in Edinburgh with Sir James Learmonth and Dr. John Gillies, the King's surgeon and anaesthetist respectively. Space does not permit an account of anaesthesia in Edinburgh but a brief anecdote in connection with the recent surgery of the King might be of interest. The medical men responsible for the King's welfare decided that an operation would be to the King's advantage. The day was set. The day previous Doctors Learmonth and Gillies came down from Edinburgh to London, lodging at a hotel near Kings Cross. The morning of the operation the two doctors left their hotel, went via the under ground from Kings Cross to Green Park station on Piccadilly. Coming to the surface they walked across Green Park to Buckingham Palace, presented

their credentials to palace officials and were admitted. The result of their labors is known in the improved condition of His Majesty. Let us attempt to reconstruct the picture on this side of the Atlantic. A luxurious staff car preceded by a motorcycle escort would whisk the distinguished occupants to their destination. Numerous photographers and reporters would greet them on arrival. I can think of no country save England where an event touching the heart of the people so closely could occur with such "sang froid" of all those directly connected with the event.

Dr. Gillies has an individual technique for thoraco-lumbar splanchnicectomy and sympathectomy (Anaesthesia, October, 1948, page 134). He uses 150-200 mgms. of Novocaine dissolved in 3-4 ccs. of cerebro-spinal fluid. The lumbar tap is between 1-2 or 2-3. The head is quickly lowered as in deep Trendelenburg. The systolic blood pressure drops to 70 or even 50 mms. of Hg. No diastolic sounds can be heard and the pulse is not palpable. I saw this technique at Edinburgh. As one would surmise the bleeding from the wound was minimal. The operation should be completed within the hour to achieve the maximum benefits from the subarachnoid block.

Another profitable and enjoyable morning was at All Saints Hospital, Southwark, London, with Dr. Terence Millin. This hospital is surrounded by homes of workers in a low income group. At the station I made inquiry of a woman for All Saints. She said, "You mean the urinary hospital." Dr. Millin makes retropubic removal of the prostate gland an apparently simple procedure. He is a fast dextrous operator while his nimble Irish tongue keeps pace with his hands upon matters, clinical and otherwise. The anaesthetist in association with Dr. Millin used pentothal induction for surgery followed by I.V. curare and cyclopropane with a circle filter CO_2 absorber.

I spent considerable time at the Royal Cancer (Free) and the Brompton Chest hospitals, London. At the former hospital, Dr. Lewis, the anaesthetic registrar, gave a pentothal induction followed by a nitrous oxide-oxygen sequence with an old McKesson machine (for a total laryngectomy). No CO_2 absorption was used as Dr. Lewis had the anaesthetic gases flowing to the patient under slight pressure. After the operation progressed to a certain point the tracheal tube (through which the inhalation anaesthetic has been administered to date) was cut off orally as low down in the pharynx as possible. The surgeon then pulled the proximal cut end of the tracheal tube into an external opening in the skin below the chin. A sterile rubber tube was attached to the tracheal tube at one end and the gas machine at the other. The operation continued. When the surgeon severed the trachea a sterile tracheal tube was placed in the proximal portion of the trachea with suitable connections to the gas machine. The carcinomatous mass including what remains of the original tracheal tube was extracted through the opening in the anterior pharyngeal wall.

For subarachnoid block Dr. Lewis chooses Nupercain Heavy solution for most abdominal surgery. The patient receives sufficient pentothal solution I.V. to produce unconsciousness, heavy nupercain is injected intraspinally, the patient is turned upon his back and an intratracheal tube placed under vision. This tube is connected with a machine with nitrous-oxide oxygen. Dr. Lewis is of the opinion that all patients should be asleep during surgery. Also that the incidence of spinal headaches was reduced if the patient was unconscious before the spinal tap.

Dr. Price Thomas is the senior surgeon at the Brompton Chest Hospital and Dr. I. V. Magill (of Magill tube fame) is the senior anaesthetist. Dr. Magill is a delightful Irishman who visited Winnipeg in 1930 with the British Medical Association. He had the misfortune to have his house demolished by a bomb during the late war. Dr. Magill uses a somewhat complicated technique for lung surgery For a pneumonectomy he first introduces a "blocker" under local anaesthesia. A "blocker" is a 24-inch rubber tube (slightly larger than a Levine tube) with an inflatable rubber balloon upon the distal end and a stainless steel stilette within the tube. The "blocker" is placed in the main bronchus of the affected lung through a special bronchoscope. The balloon at the end of the blocker is inflated, and the tiny catheter leading to the balloon is clamped. The blocker, stillete and tiny catheter all lie at the side of the patient's mouth. Now a tracheal catheter with a balloon on its distal portion is placed in the trachea about one inch below the true vocal cords. This balloon is inflated and the catheter is connected with a gas machine. This technique prevents the spilling of infected material from the affected to the sound outside. Before the surgeon cuts the main bronchus of the affected side, the balloon of the blocker is deflated, the balloon of the tracheal tube also, and then the blocker is withdrawn from the lung. This all sounds rather formidable but in experienced hands the technique is not too time consuming. Dr. English, one of the attending anaesthetists at the Brompton, gave an excellent demonstration of paravertebral block for thoracoplasty. T.1 to T.9 were blocked upon the affected side in addition a wide subscapular block. The operation continued over two hours and no intravenous or inhalation anaesthesia was required. At both hospitals blood was given freely during surgery.

Some 400 anaesthetists from all parts of the United Kingdom attended the monthly meeting

at 1 Wimpole St., London. The programme of four papers was well received, but the discussion limited on account of the annual dinner which followed. Dr. Schaffer, a son of the noted physiologist, wittily and pungently drew attention to the number of anaesthetic agents used during one operation. He suggested that not all anaesthetists were fully acquainted with the actions and reactions of each drug used during anaesthesia. He made a strong plea for the use of fewer anaesthetic agents in a single operation. Until, as he said, we know all there is to know about each agent. He stated that it was impossible to get accurate data upon the effect of one anaesthetic agent when a number of anaesthetic drugs were combined.

Health Insurance or, to be correct, the National Health Service Act has passed the first year. Is it a success? I would suggest that whatever party governs England, N.H.S.A. will remain. The public are "sold" upon the benefits of the act. Their contribution towards the scheme include out-of-work, sickness and pension benefits. Most people are of the opinion that the doctors absorb the vast sums involved and still complain. I understand that of the monies received under this act the doctors' share is 10%.

The doctor who suffers the heaviest financial sacrifice is the man who has had a small panel practice and a moderate to large clientele of private patients. This man probably is around middle-age, his children in high school or college. He finds his income has been cut 50% or more under the N.H.S.A. while his expenses continue as before. It would appear that the scheme is suffering from acute indigestion. The consumption of too many indigestible ingredients at one gulp tests even a British stomach. In its present form National Health would not be acceptable to the Canadian people. The doctors in Canada, by exercising their franchise, have little hope of influencing legislation but individually each doctor has a wonderful opportunity by precept and daily life to demonstrate the advantages to the public of free medicine, i.e., medicine free from bureaucratic control. How long are we to enjoy medical independence? It depends upon you (us all).

Britain has tried to make this island a post-graduate medical centre. These efforts have not been in vain. I noted in the visitors book at the Brompton Chest Hospital the names of men from Ceylon, South Africa, India, Columbia, Argentina, China, Australia, United States and Canada.

A trip to Britain is a memorable event. Nature has been very kind in the lovely rolling countryside and even temperature. Perhaps the geography and climate have something to do with the delightful, even-tempered people who accept without complaint conditions that would incite us to rebellion. I am very happy to be home in Canada.

However, I believe that world events and geography rather than our individual efforts have contributed to the making a desirable place of our country. Should we accept this statement many of us might take a more charitable view of the difficulties encountered by our colleagues in post-war Britain.

Announcement of Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Houston, Texas, March 9, 10 and 11, 1950, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. George C. Shivers, 100 East St. Vrain Street, Colorado Springs, Colorado, not later than January 15, 1950. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the programme of the annual meeting for presentation of the Prize Award Essay by the author, if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association.

EDITORIAL

J. C. Hossack, M.D., C.M. (Man.), Editor

The Doctor as Salesman

It is to our own great advantage to "boost" the M.M.S. And not to our advantage only but to that of everyone in the community. It should be our aim to make province-wide acceptance of this plan complete and speedy. Only in that way can we be sure of retaining a reasonable control over our professional activities.

Now, this is your business as much as it is that of your representatives. Indeed it is especially your business for it is you who will gain or lose by the events of tomorrow. Therefore every doctor should become a salesman of this service.

That is not difficult. A patient visits you to pay his bill of say $150.00. Already he may have paid a hospital bill of equal size. As you hand him his receipt nothing is more natural than to point out that the $300.00 he has paid equals five years' premiums which would have covered not only himself but his family also.

Whether the patient comes from City or Country that statement is enough to make him think. In the case of the City-dweller he will seek ways of enrolling. In the case of the rural patient he will be receptive to arguments advanced in favour of establishing the service in his locality.

We doctors as individuals can do a tremendous amount of advertising of our own time-tried plan. It would, we believe, be wise to prepare pamphlets which could be placed in waiting rooms or handed to patients. Then, with the details of the plan before them, they could not only act themselves but would encourage others to act so that every area would become a fertile and easily harvested field when it is canvassed for subscribers.

Dr. A. E. Archer

The sudden passing on May 23rd last of Dr. A. E. Archer, at the hospital which he had founded at Lamont, Alberta, was a loss to medicine of all Canada, but particularly to the Canadian West. Born in 1872, in a Methodist parsonage in Ontario, he graduated in medicine from the University of Toronto, came in 1903 to Star, Alberta, and three years later moved to the newly-founded town of Lamont. There he made his home and practised until his death. So closely was his life interwoven with this community that Archer and Lamont came to be almost interchangeable terms.

Working in this rural area, and always ready to serve, he grew in medical stature until in 1942 he was elected President of the Canadian Medical Association at its meeting in Jasper. From 1946 till his death he was adviser in economics to that body and, as such, visited every province of the Dominion and became familiar with its problems.

In 1943 the University of Manitoba awarded Dr. Archer the Honorary Degree of Doctor of Laws and at the same convocation he addressed the new graduates in medicine of the University. As adviser in economics of the parent body, he sat in on several occasions at meetings of the Executive of the Manitoba Division where those present learned to appreciate his wise and prudent counsel.

Though fame and rewards came to him, he did not seek them. He was content to do his duty, and his master word was service.

The faith learned in childhood was carried over into his daily life, and one might say of him that he lived "as ever in the great Task-Master's eye."

R. B. M.

Books for Winter Reading

Now that the holiday season is over we can plan the winter's work. Part of this is the gathering of new knowledge and the refreshment of faded memories. During the past year we have reviewed a number of more than ordinarily useful works whose titles you perhaps forgot to note at the time. Now, when you are planning your winter reading, it may be well to draw some of them to your attention.

First there are two valuable books on Diagnosis: McBryde's **"Signs and Symptoms"** ($14.00)—an analysis of some score or so of the common evidences of disease, and **"Diagnosis in Everyday Practice,"** by White and Geschickter ($17.00). This is a large, comprehensive, beautifully illustrated guide which, while it does not make diagnosis an automatic process, does make the process of solution logical and systematic.

Viral and Rickettsial Infections in Man and Bacterial and Mycotic Infections in Man compose a second pair of necessary volumes. Despite their size and abundance of black and white and colored illustrations the two volumes sell for $13.00 the pair. They deal with the clinical as well as with the laboratory aspects of these infections, thus bringing organism and host into bedside relationship. Treatment as well as symptoms is covered,

and the role of chemotherapy and of antibiotics is given special attention.

New and Unofficial Remedies ($3.50), is a guide to what has been proven good or bad among new remedies. It is a ready reference not only to what to prescribe but also to the nature and properties of, and indications for, these remedies.

Many who realize the need for a grounding in psychiatry will find an answer to most of their questions in Strecket's **Essentials of Psychiatry** ($4.50). A small but comprehensive review of syphilis in all its forms and phases (with instructions on treatment) is Kampmerer's **Essentials of Syphilology** ($6.00). There is another member of the "Essentials"—**Essentials of Dermatology** ($6.00), which will help by description and illustration those who find skin diseases puzzling and refractory.

Lately two additional volumes have come to our attention. **Female Sex Endocrinology** ($4.50), by Birnberg. This should prove instructive to those who realize the importance of the subject but have difficulty in reconciling the various views presented in the literature. The second volume is a useful summary and review of a year's progress **"Medicine of the Year"** ($5.00).

The above books are published by J. B. Lippincott, Medical Arts Building, Montreal.

J. C. H.

Defence Medical Association of Canada

The next Annual Meeting of the Defence Medical Association of Canada will be held in Toronto on the 27th and 28th of October, 1949. All members of the Defence Medical Association are cordially invited to attend.

The Friday sessions will be held in the Royal York Hotel. These will consist of a business session, an address on Civil Defence, discussions on subjects related to Medical Aspects of Atomic Energy, Radioactive Isotopes, Aviation Medicine, Air Transport of Sick and Wounded and training at Universities and in the Forces generally.

At the luncheon and annual dinner to be held on Friday at the Royal York Hotel addresses will be given by leading authorities on some of these same subjects.

The Saturday morning session will be held at the Institute of Aviation Medicine when the Association will be the guests of the Royal Canadian Air Force.

The object of the Association is to develop the efficiency of the Canadian Defence Medical Services by the dissemination of knowledge throughout the Dominion on defence medical affairs, thus creating a greater interest among a larger number of medical officers and civilian practitioners.

Membership is open to all Medical graduates who have served or are now serving in any of the Medical Services of the Navy, Army or Air Force, active, reserve, or supplementary reserve.

The annual meeting and annual dinner of the Manitoba-Lakehead branch D.M.A. will be held separately in early October prior to the annual meeting at dates to be announced later.

Further particulars may be obtained by applying to the branch secretaries.

Saskatchewan: Dr. G. C. Bradley, 812 McCallum-Hill Bldg., Regina, Sask.

Manitoba: Dr. P. K. Tisdale, 501 Medical Arts Bldg., Winnipeg, Man.

Annual Dinner, Officers Mess, Fort Osborne, October 21, 1949, at 6.15 p.m.

The Saga of . . .
Four Busy Painters
or . . .
Pull Down That Blind!!

By Anonymous.

The painters are painting,
  Our patients are fainting,
And why, do your suppose??
  Well wouldn't you faint,
If a painter should paint?
  And you're lying without any clothes??

On some other building,
  They only were willing,
A single coat to apply,
  But when they got peeking,
(More girls they were seeking)
  "More paint!!" was their glad hearted cry.

So onward they go,
  Through the rain and the snow,
To some other job they must flee,
  But their heart isn't in it,
Cause it isn't a Clinic,
  And no more pretty girls will they see.

Note: The Medical Arts Building is getting a new paint look.

SOCIAL NEWS

Reported by K. Borthwick-Leslie, M.D.

Another Manitoba Medical Convention and Annual Meeting, come and gone! Congratulations and "Heaven Help" you to all the new Slate of Officers, particularly our old friend, Tony Scott, President.

♦

Dr. E. T. Feldsted, Radiologist, is now doing Research work in the Royal Cancer Hospital, London, England, having completed post-graduate study at Chalk River, Vancouver, and the U.S.A.

♦

Speaking of Chalk River, Dr. Harold Blondal and wife Pat, arrived there safely and are settled down to years of concentrated research.

♦

It is with regret that we say "Au Revoir" to J. C. Colbeck, M.D., B.S., M.R.C.S., L.R.C.P., Director of the Provincial Laboratory. He goes west, I understand, in search of climate, environment and co-operation.

♦

Dr. L. P. Lansdown, formerly Director of the Swan Valley Health Unit, has been appointed Pathologist at the Provincial Laboratory.

♦

The Anaesthesiologists bade farewell to Dr. and Mrs. Fred Walton at a most enjoyable dinner at the Fort Garry Hotel. Fred also goes west to New Westminster, B.C. Our loss will be their gain.

♦

Dr. Donalda Hughes, also from the General Hospital staff, and recently a "Diplomate of the American Board of Anaesthesiology" left last week by plane to visit medical centres in Sweden and England.

♦

Dr. and Mrs. J. M. Huot are in Chicago, where Dr. Huot is studying at the Dillinger Clinic.

♦

Dr. and Mrs. James Mitchell, Wildwood Park, announce the arrival of Susan, September 9th, 1949.

♦

Welcome back to Dr. Elinor Black, from all her travels and study. She looks grand, but refuses to tell your "gossip monger" details of her absence. Fine thing.

Dr. and Mrs. M. Yaholnitsky, Yorkton, Saskatchewan, announce the birth of Terence Peter, a brother for Michael.

♦

The first meeting of the Medical Women's Branch of the Canadian Federation took place at the home of the new President, Dr. Jessie McGeachy. A delightful buffet supper, good attendance, and informal announcement of an interesting programme for the coming year.

♦

Dr. and Mrs. H. Bruce Chown have returned from the Continent, arriving in Toronto just in time to attend the wedding of Bruce Farrell Chown (elder son of Dr. Bruce's) to Margaret Ida Wilde, daughter of Mr. and Mrs. Forrest Wilde, on Sept. 17th. Both bride and groom are graduates of the University of Manitoba.

♦

September 3rd, in the First Presbyterian Church, Margaret M. Swan, daughter of Dr. and Mrs. Alex. Swan, became the bride of Norman Gilbert, son of Mr. and Mrs. David Gilbert. The bride's sister, Alexa Swan, Washington, D.C., was maid of honor.

♦

September 10th, in Augustine United Church, Betty Munro, daughter of Mr. and Mrs. F. W. Munro, became the bride of Alan A. Williams, son of Mrs. Gerald S. Williams and the late Dr. Gerald Williams.

♦

The wedding of Mary E. Boreham, daughter of Mr. and Mrs. Bruce Boreham to Dr. Wm. Alexander MacLean, son of Mrs. W. J. MacLean and the late Rev. Dr. MacLean, took place October 1st.

♦

Sorry if I missed anyone, holidays, well earned, kept me out of circulation for a couple of weeks, and my stooges didn't do very well!

♦

Dr. and Mrs. Myron Feinstein, with small daughter, visited their parents in Winnipeg. Rumor reports that Myron will take up residence here, but I haven't found out for sure! If so, welcome back.

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

M. T. Macfarland, M.D., Registrar

(Continued From September Issue)

September 8th, 1949—Registration Committee

Enabling Certificate Confirmed: Huu Thoi Trieu, M.D., U. Paris, 1936.

Enabling Certificates Granted: Jan Silny, M.D., Masaryk U., Brno, Czechoslovakia; M.D., C.M., McGill U., 1948. Jean DeWitt Fox, M.D., College of Medical Evangelists, 1945; D.N.B., 1946. Galen Homer Coffin, B.Sc., Walla Walla College, 1943; M.D., College of Medical Evangelists, 1949; D.N.B., 1949. Chin-ming Ling, B.Sc., Soochow U., 1937; M.D., Peiping Union Medical College, 1940.

Registrations Confirmed: Huu Thoi Trieu, M.D., U. Paris, 1936; L.M.C.C., 1949. Andre Louis Molgat, B.M., Laval U., 1945; M.D., Laval U., 1948; L.M.C.C., 1948. Joseph Herve Boucher, M.D., Laval U., 1949; L.M.C.C., 1949. Douglas Lawrence Kerr, M.D., C.M., McGill U., 1943; L.M.C.C., 1943.

Registrations Granted: Ian Walter de Grave Gregory, L.R.C.P., Lond., 1948; M.R.C.S., Eng., 1948; M.B., B.Chir., U. Cambridge, 1948. John Gideon Foster, M.D., College of Medical Evangelists, 1927; D.N.B., 1927; L.M.C.C., 1949. Ashby Eddleston Carter, M.D., College of Medical Evangelists, 1929; L.M.C.C., 1931. Hsueh-yen Tso, B.S., Yenching U., 1927; M.D., Peiping Union Medical College, 1931; L.M.C.C., 1949. Denys Macdonald Irving Harmar, L.R.C.P., Edin., 1931; L.R.C.S., Edin., 1931; L.R.F.P.S., Glas., 1931; M.B., Ch.B.. U. Birmingham, 1932; D.P.H., U. Birmingham, 1947.

Temporary Licences Confirmed: Benjamin Shuman, M.D., U. Toronto, 1942; L.M.C.C., 1942. Victor H. Radoux, B.A., U. Ottawa, 1935; M.D., U. Laval, 1943; L.M.C.C., 1943.

Temporary Licence Granted: John Lendrum Johnston, M.D., U. Toronto, 1943; L.M.C.C., 1943.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1949		1948		Total	
	July 17 to Aug. 13,'49	June 19 to July 16,'49	July 11 to Aug. 7,'48	June 13 to July 10,'48	Jan. 2 to Aug. 13,'49	Dec. 28,'47 to Aug. 7,'48
Anterior Poliomyelitis	12	4	18	4	24	25
Chickenpox	31	107	123	311	910	1975
Diphtheria	2	1	4	5	15	18
Diphtheria Carriers	0	0	0	2	2	3
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	1	3	1	1	8	5
Erysipelas	0	3	2	3	18	23
Encephalitis	3	0	0	0	3	1
Influenza	9	9	2	5	161	121
Measles	129	405	56	120	4916	506
Measles—German	4	6	2	0	95	33
Meningococcal Meningitis	0	3	2	2	17	10
Mumps	18	44	70	110	884	1347
Ophthalmia Neonatorum	0	0	0	0	0	0
Pneumonia—Lobar	7	14	5	10	135	117
Puerperal Fever	0	0	0	0	2	1
Scarlet Fever	4	9	17	12	68	155
Septic Sore Throat	0	1	1	2	23	15
Smallpox	0	0	0	0	0	0
Tetanus	1	0	1	1	2	3
Trachoma	1	0	1	0	1	1
Tuberculosis	124	85	74	312	566	1180
Typhoid Fever	1	1	1	1	6	6
Typhoid Paratyphoid	0	0	1	1	0	2
Typhoid Carriers	1	0	0	0	2	0
Undulant Fever	2	0	0	0	8	11
Whooping Cough	8	20	17	5	138	225
Gonorrhoea	125	125	118	126	860	892
Syphilis	35	34	33	33	268	314
Diarrhoea and Enteritis, under 1 yr.	23	13	8	11	118	126

Four-Week Period July 17th to August 13th, 1949

DISEASES (White Cases Only) *Approximate population.	*743,000 Manitoba	*906,000 Saskatchewan	*3,825,000 Ontario	*2,962,000 Minnesota
Anterior Poliomyelitis	12	9	386	406
Chickenpox	31	140	237	—
Diarrhoea and Enteritis	23	14	—	—
Diphtheria	2	—	—	4
Dysentery—Amoebic	—	—	2	8
Dysentery—Bacillary	1	—	1	6
Influenza	9	7	21	5
Erysipelas	—	5	3	—
Encephalitis	3	4	1	—
Malaria	—	—	—	4
Measles	129	523	224	52
Measles, German	4	50	22	—
Meningococcal Meningitis	—	—	7	5
Mumps	18	114	165	—
Infectious Jaundice	—	—	3	—
Pneumonia Lobar	7	—	—	—
Septic Sore Throat	—	4	5	—
Scarlet Fever	4	5	54	11
Tetanus	1	—	—	—
Trachoma	1	—	—	—
Tuberculosis	124	44	56	242
Typhoid Fever	1	—	15	2
Typh. Para-Typhoid	—	—	7	—
Typhoid Carrier	1	—	—	—
Undulant Fever	2	—	3	34
Whooping Cough	8	18	89	7
Gonorrhoea	125	—	183	—
Syphilis	35	—	75	—

DEATHS FROM REPORTABLE DISEASES

For Four-Week Period July 13th to August 9th, 1949

Urban—Cancer, 52; Pneumonia (other forms), 6; Syphilis, 4; Tuberculosis, 5; Hodgkin's Disease, 1; Mumps, 1; Diarrhoea and Enteritis, 2. Other deaths under 1 year, 17. Other deaths over 1 year, 173. Stillbirths, 17. Total, 207.

Rural—Cancer, 17; Influenza, 1; Pneumonia Lobar (108, 107, 109), 1; Pneumonia (other forms), 4; Syphilis, 1; Tuberculosis, 6; Cerebrospinal Meningitis, 1; Diarrhoea and Enteritis, 5. Other deaths under 1 year, 19. Other deaths over 1 year, 146. Stillbirths, 8. Total, 173.

Indians—Cancer, 1; Influenza, 6; Measles, 2; Pneumonia other forms), 5; Tuberculosis, 2. Other deaths under 1 year, 2. Other deaths over 1 year, 2. Total, 4.

♦

Anterior Poliomyelitis—At date of writing (September 13th) 61 cases have been reported and of these four have died.

Encephalitis—At the same date 13 cases reported and two have died. Some of these cases have been proved to be Western Equine type by neutralization tests.

Measles—The epidemic seems to be pretty well over for this time.

Tuberculosis—The surveys are finding quite a number of cases, especially among Treaty Indians and halfbreeds, but this disease is showing a definite decrease.

Venereal Diseases show a slight decline but are still a problem. Health education, early case finding and thorough treatment should produce results.

1949
COMMITTEE REPORTS

Manitoba Medical Association
(Canadian Medical Association, Manitoba Division)

Executive

To the Executive Committee and Members of The Manitoba Medical Association:

This report covers the activities of the Executive Committee for the eleven-month period since the last Annual Meeting, during which time there have been eight regular meetings with an average attendance of seventeen members.

1. Date of Annual Meeting.

Last fall a resolution was passed that the date of our Annual Meeting be set following communication with the Canadian Medical Association. The dates which were arranged to accommodate members of the C.M.A. travelling team presented a serious overlapping with the Alberta Division. Inasmuch as Commercial Exhibits are of importance to all Divisions one week should be devoted to each of the Divisional meetings.

2. Office Accommodation and Equipment.

Adequate space is now available but the removal of the present partitions to provide more efficient utilization and lighting is recommended. The increase in rent which was reported last year was accompanied by a corresponding increase in business tax assessment. Notification was received that a charge would be made for use of the Medical Arts Clubroom for non-scientific meetings held on week-day evenings or Sundays. The cost of an adding machine was shared by the Winnipeg Medical Society and College of Physicians and Surgeons, and that of a dictating machine by the latter body.

3. Office Staff.

The three members of the secretarial staff have carried the combined duties of the College of Physicians and Surgeons of Manitoba, the Manitoba Medical Association, and the Winnipeg Medical Society with genial co-operation and pleasant efficiency. Assistance was given to other bodies, notably the committee which arranged the Post-Graduate Refresher Course for the University of Manitoba in April. With increasing demands additional secretarial help will be required. Salaries were not increased but a cost-of-living bonus was made effective on November 1st, 1948. During the year the College of Physicians and Surgeons authorized a larger monthly payment to the Association towards the expenses of rental, light and secretarial help.

4. Executive Secretary.

This office was included in the 1948 revision of the Constitution and By-Laws. Since the fall of 1947 when, following negotiations of the Liaison Committee, the Executive Secretary of the Association was appointed Registrar of the College, the work of the latter body has been greatly increased by correspondence with or concerning personnel from the British Isles and Europe seeking licensure as physicians in this Province. The College has assumed a greater proportion of the salary but further revision may be necessary.

5. Membership.

A most encouraging report will be presented by the Chairman of this Committee. Action was taken to clarify the situation with respect to the fee payable by salaried doctors. It was agreed that those in private practice, those whose accounts are submitted on a fee-for-service basis, or those employed by an individual or group rendering accounts on a fee-for-service basis, should pay the full $35.00 fee, since arrangements may usually be made with the employer to divide the salary to care for legitimate expenses. This means that only recent graduates and those who are employees of Federal or Provincial Governments, or other bodies which do not render accounts on a fee-for-service basis, will be eligible for the $15.00 fee.

By resolution of General Council in June, the Canadian Medical Association decided that the annual rebate of $2.00, which was allowed to the Divisions during the war years, be discontinued, beginning January, 1950, when the full fee of $10.00 for C.M.A. membership will become operative. The payment of the additional $2.00 for each member of our Association will mean an annual decrease in M.M.A. revenue of approximately $1,300.00. The Executive Committee decided that the joint fee should remain at the present level.

6. Anaesthetists.

In December of last year the Anaesthetists of Greater Winnipeg sought a change from salary to a fee-for-service basis. Several individuals brought the problem to the Association and secured support for the principle. This was followed by an appeal for assistance in securing the objective. The profession and hospitals were circularized and the matter was discussed with the anaesthetist group by the Economics Committee. It is recognized that the anaesthetists have the right to expect fee-for-service, also that the hospitals have the privilege of employing salaried anaesthetists. A solution of the problem lies in co-operation between the two, and negotiations to this end are in progress at the present time.

7. Canadian Arthritis and Rheumatism Society.

This organization with a federal charter is seeking the formation of provincial divisions. Initial finances are from a one per cent grant from the General Public Health Grant agreed to by the provinces, but subsequent financing will be by campaign subscription. An Association representative has been named and a provisional committee has been formed. Application has been made for a part-time Executive Secretary, whose salary will be paid by the parent Society. Outpatient clinics for indigent arthritic patients are to be established at the teaching hospitals. Inasmuch as the Canadian Medical Association did not approve the principle of setting up pilot plants for the treatment of civilian arthritics in Department of Veterans Affairs hospitals but did agree to conduct an Arthritis Survey, it is anticipated that there will be close co-operation between the C.M.A. representative and local organization. Various scholarships have been announced by the Canadian Arthritis and Rheumatism Society.

8. 80th Annual Meeting C.M.A.

The meeting held in the Bessborough Hotel, Saskatoon, on June 13th-17th, had been preceded by the second gathering of the Commonwealth Medical Council. C.M.A. General Council met on June 13th and 14th, and the following representatives from Manitoba Division attended: Doctors V. F. Bachynski, H. S. Evans, A. M. Goodwin, A. T. Gowron, M. T. Macfarland, J. R. Martin, P. H. McNulty, R. W. Richardson, D. L. Scott, C. H. A. Walton and C. W. Wiebe.

Attention of members is directed to the "Statement of Policy" which was agreed upon by General Council after the Chairman had reconvened members in overtime session. Details of the meetings are to be found in August C.M.A. Journal and a copy of the Statement is reprinted in the current issue of the Manitoba Medical Review.

At the Annual General Meeting held on Wednesday evening, Dr. J. F. C. Anderson was installed as President, and Senior Membership was conferred on representatives of the various Divisions, including Dr. W. H. G. Gibbs, Selkirk (in absentia).

9. Cancer.

The interest shown by members of the profession last year when the report of representatives to the Cancer Relief and Research Institute was presented has been greatly increased by the provision by the Union of Municipalities, the Provincial and Federal Governments of funds for establishing, among other things, Cancer Diagnostic Clinics for the residents of rural Manitoba. A plan evolved by the Medical Advisory Board was tentatively approved on condition that the details be submitted to the Association for confirmation. Reconsideration was requested when the scheme had been discussed with representatives of those institutions which would assume responsibility for the clinics. Subsequently, the plan was referred by the Institute to two teaching hospitals concerned, and it is likely that alternative proposals will be dealt with at this Annual Meeting. Copies of Special Select Committee of Manitoba Legislature and 1948 Report of Cancer Relief and Research Institute were forwarded to members during the year. A film, "The Early Diagnosis of Cancer," made available by the National Cancer Institute to each Division of C.M.A., may be utilized by District Medical Societies for professional education.

10. Constitution and By-laws.

Copies of the revised Constitution and By-laws were printed and are available on request to all members of the Association. A copy will be given to each new member enrolled in the Association.

11. Deanship, Medical College.

The Association and the College of Physicians and Surgeons were asked, jointly, to name one member to a committee to consider the possible successor to the one who has directed medical education at the University of Manitoba for the past seventeen years. Honours were conferred upon the retiring Dean at the last convocation, and his successor enters upon his duties with the best wishes of his confreres.

12. Manitoba Division C.M.A. Advisory Committee to D.V.A.

No meeting of this Committee has been held during the year and it is proposed that the Committee be discontinued.

13. District Medical Societies.

Increased activity of Societies this year is reflected in the fact that for the first time in several years the grant made by the College of Physicians and Surgeons to assist in defraying the expenses incurred by the various speakers has been found insufficient to cover the outlay.

14. Federal Health Grants.

Copious references to the various projects submitted and approved since the first announcement by the Prime Minister in May, 1948, have been made in the Federal and Provincial Houses, in the daily press and periodical publications, professional and lay. It is rather significant that the Health Survey Committee, which was to be set up for the express purpose of reviewing the provincial situation and evolving an overall plan, has not yet been called to meet. The suggestion has been made that much of the survey work was done prior to the introduction of the Health Services Act. Projects submitted locally are reviewed by the Central Advisory Committee, an interdepartmental, non-administrative body, on which there is an Association representative. Where they concern aspects of Public Health, Cancer or Tuberculosis Control, or Hospital Construction, they are referred to the Provincial Board of Health, Cancer Relief and Research Institute, Sanatorium Board or Hospital Council respectively. All are reported to the Advisory Commission under the Health Services Act for information or for advice and report. Three Association members are active in connection with the survey of Crippled Children in the province, and various clinics have been held in city and rural areas, but no report is yet available. A subcommittee of this Association has actively considered Mental Health projects and is seeking support for projects which are considered essential. It should be remembered that the federal grant is a matching grant for moneys appropriated by the province in Hospital Construction, Cancer and Veneral Disease Control.

15. Fee Revision Committee.

The work of this joint M.M.A.-M.M.S. Committee was held in abeyance while negotiations for equalization of fees paid by Manitoba Medical Service to General Practitioner and Specialist members were in progress. When, however, after many lengthy sessions the committee reported, the document contained 29 pages. It was accepted by the Executive Committee for use by Manitoba Medical Service. A new Fee Committee was set up to consider representations from interested groups or individuals.

16. Group Insurance.

When the Group Insurance Committee reported favourably on a plan submitted by the North American Life and Casualty Company, Minneapolis, a questionnaire was sent to each member of the profession. The Company's representative carried out the active solicitation and the effective date of the coverage was December 29th, 1948. All members had the opportunity to enroll for thirty days without evidence of insurability and that privilege is also extended to all new members who may join the Association. Requests have come from members who have since moved from the province for continuation of membership in order that the accident and sickness policy may be renewed.

17. Health Services Act.

A committee was set up during the year to study the operation of the Manitoba Health Services Act. When a complete report is available it will then be possible to bring this information to the attention of the authorities responsible for the administration of the plan.

18. Legislation.

For an outline of legislation which might be of interest to the medical profession members are directed to page 373 of the July, 1949, copy of the Manitoba Medical Review.

19. Liaison Committee.

Matters of concern common to the College of Physicians and Surgeons of Manitoba and the Manitoba Medical Association continue to be discussed at meetings of this joint committee. A report is then taken to each parent body and appropriate action suggested. A very fine spirit of co-operation has greatly enhanced the value of this committee to the profession as a whole.

20. Manitoba Medical Review.

Evidence that the Review is a popular monthly periodical is available in the great number of unsolicited testimonials or animated discussions which come to the ear of the Editor, the Business Manager or the Executive Secretary. More concrete is the occasional letter like that recently received from an Honorary Member resident in England, and the international requests for individual articles or back numbers of the Review, including a sixteen-month period. May the good work continue!

21. Manitoba Medical Service.

During the year the co-operation of the Association Executive was solicited to effect extension of the scheme of providing prepaid medical care to rural areas of the province. It was necessary first to circularize all the members of the profession to acquaint them with the plan and solicit their co-operation. The Medical Director was advised of District Medical Society meetings, and attended at Dauphin, Brandon and Altona. The Past-President visited Flin Flon and discussed the scheme. Further impetus was given by the removal of all salary limitations with no provision for extra-billing. The revised Fee Schedule became effective on April 1st. A committee is studying the problem of specialist status. When the provincial government sought arrangement with the hospitals for diagnostic facilities for adjacent rural municipalities, and the City of Winnipeg, through the Health Committee of its Council, requested infor-

mation concerning diagnostic facilities for the residents of Winnipeg, the Manitoba Medical Service was asked to study and report on the feasibility of a plan which would provide the desired coverage.

22. Multiple Sclerosis Society.

Not to be outdone by other organizations, a Canadian Society paralleling that of the U.S.A. was brought into being, and, like the Canadian Arthritis and Rheumatism Society, it was hoped that provincial chapters might be formed, and that a financial grant might be expected from the General Public Health Grant made available by the Federal Government. During the present summer a survey of the Multiple Sclerosis cases in the Greater Winnipeg area was sponsored by the National (U.S.A.) and Canadian Societies and actively carried out by students of the Faculty of Medicine with the full knowledge and blessing of the Dean and the Professor of Social and Preventive Medicine. It is not anticipated that results will be available for some months, but should be of interest to all bodies concerned.

23. Pension Plan.

The committee set up to consider the advisability of adopting such a plan for practising members of the profession has done considerable work, and may be reporting progress at this meeting.

24. Public Relations.

Earlier this year the Canadian Medical Association Executive appropriated a sum of money to be devoted to improving public relations, and asked for key men to be selected by the Provincial Divisions and District Medical Societies to inform the parent body of matters requiring attention. Since the C.M.A. Annual Meeting in June, a copy of "Statement of Policy" has been sent to each of these representatives.

25. Sections.

Last year two groups became affiliated with the provincial body, the Neuropsychiatric, and the General Practitioners' Association of Manitoba. Other groups were encouraged to affiliate and the latest to do so are Internist and Radiologist groups. The Anaesthetist and Pathologist groups are organized and the formal application will probably be made. Advantages of this affiliation is direct access in matters such as revision of fee schedules. Sections raise funds to support their own activities.

26. City of Winnipeg Diagnostic Facilities.

Various aldermen in City Council inquired whether the City should seek to participate in so-called Diagnostic Units provided under the Health Services Act. A questionnaire was circulated by the Medical Officer of Health to all doctors in Winnipeg. The results were extremely interesting and informative. A copy of the report with comments was circulated to all medical men to whom the original questionnaire was sent. Additional information concerning coverage of the lower income groups by Manitoba Medical Service is now being sought.

27. Workmen's Compensation Board.

The Supplementary Report presented at the Annual Meeting was printed in November, 1948, copy of the Manitoba Medical Review. The new schedule was effective on October 1st, 1948, and provided for a Taxing Committee of the Association. A roster was named and a nominal fee set for remuneration. The Liaison Committee M.M.A.-C.P. & S. requested the latter body to assume payment of the Committee and it was agreed that the C.P. & S. should do so through its own Fee Taxing Committee. The plan has not worked satisfactorily and an alternative method will probably be passed back to this Association. It is essential that the committee named should have the confidence of the Commissioner and officials of the Board.

28.

No report would be complete without an expression of appreciation to all members who have participated so wholeheartedly in the affairs of the Association during the past year.

H S. Evans,
President.

A. M. Goodwin,
Honorary Secretary.

Honorary Treasurer

To the President and Executive of
The Manitoba Medical Association:

29.

Herewith certified financial statement from our auditors, Messrs. Thornton, Milne and Campbell, for the year 1948, also supplemental statement, prepared by the office, to August 31st, 1949.

All of which is respectfully submitted.

C. B. Schoemperlen,
Chairman.

To the Members,
Manitoba Medical Association,
Winnipeg, Manitoba.

Dear Sirs:

In compliance with your request, we have made an audit of the books and accounts of your Association for the year ended 31st December, 1948, and submit herewith our report thereon, together with the following relative financial statements:

EXHIBITS:

"A" Statement of Assets and Liabilities as at 31st December, 1948.

"B" Statement of Revenue and Expenditure for the year ended 31st December, 1948.

The excess of Revenue over Expenditure for the year, as set forth in Exhibit "B," amounted to $3,314.96. Membership fees received are in accordance with duplicate receipts on file and were reconciled with the membership cards issued. In accordance with the minutes of the meeting held on the 13th of December, 1947, the sum of $175.00 per month has been received from the College of Physicians and Surgeons covering their portion of the general office expenses. The receipt of $600.00 from the Manitoba Medical Service constituted the final payment on a $1,000.00 loan made to this body in previous years. The amount paid to Dr. Hossack is in accordance with the minutes of the meeting held on 14th November, 1948. All expenditures have been properly authorized and satisfactory vouchers were produced for our inspection.

Relative to our examination of the various items comprising the Statement of Assets and Liabilities, marked Exhibit "A," we would comment as follows:

CASH ON HAND AND IN BANK, $875.34: We did not count the cash on hand. The cash in bank was reconciled with a certificate received from the Bank of Montreal, subject to an allowance for outstanding cheques, amounting to $1,450.00, as shown by the books.

ACCOUNTS RECEIVABLE, $933.05: Accounts Receivable on behalf of the Review are considered to be fully collectible. The amount owing from the College of Physicians and Surgeons represents expenditures made by the Association on behalf of Extra Mural Services.

INVESTMENTS, $10,066.94: We examined the bonds comprising this asset and found same to be in order. The market value of the investments at 31st December, 1948, was $10,550.87; this represents an appreciation in value over cost of $483.93.

GENERAL REMARKS

In view of the inadequate coverage afforded by your existing fidelity bond, we would suggest that due consideration be given to having at least a portion of the Association bonds changed from their present form, coupon bearer bonds, to coupon registered securities.

In conclusion, we wish to report that we found the records satisfactorily kept and that all our requirements as auditors have been compiled with.

Yours very truly,

THORNTON, MILNE & CAMPBELL,
Chartered Accountants

Exhibit "A"

Statement of Assets and Liabilities As at 31st December, 1948

30.

ASSETS

Cash:		
Petty Cash on Hand	$ 20.00	
Bank of Montreal	855.34	
		$ 875.34
Accounts Receivable:		
Review Advertisers	687.67	
Advance Expenses paid on Review	127.78	
College of Physicians and Surgeons	117.60	
		933.05
Investments:		
Province of Manitoba:	Par	Cost
4½%, 1956	$2,000.00	$1,957.12
Canadian National Railway:		
5%, 1969	1,000.00	1.086.07
Dominion of Canada:		
3%, 1951	2,000.00	2,000.00
3%, 1952	2,000.00	1,975.00
3%, 1957	1,000.00	1,000.00
3%, 1959	500.00	500.00
3%, 1963	500.00	500.00
3%, 1966	1,000.00	1,048.75
		10,066.94
Office Furniture and Equipment	487.37	
Less: Reserve for Depreciation	487.37	
		$11,875.33

LIABILITIES

Surplus Account:		
Balance as at 31st December, 1947	$8,560.37	
Add: Excess of Revenue over Expenditure, as per Exhibit "B"	3,314.96	
		$11,875.33
		$11,875.33

Exhibit "B"

Statement of Revenue and Expenditure For the year ended 31st December, 1948

31.

REVENUE

Fees Collected:		
439 Members at $27.00		$11,853.00
142 Members at 7.00		994.00
57 Members at 11.50		655.50
6 Members at 24.00		144.00
4 Members at 13.50		54.00
2 Members at 15.00		30.00
3 Members at 4.00		12.00
1 Member at 3.50 (½ year)		3.50
		$13,746.00
College of Physicians and Surgeons		2,100.00
Winnipeg Medical Society		900.00
Manitoba Medical Service		600.00
Interest on Bonds		342.50
Sale of Doctors Lists		54.00
		$17,742.50

EXPENDITURE

General Expenses:		
Salaries:		
Dr. M. T. Macfarland	$6 000 00	
H. M. Brown	1,435.00	
J. Allison	1,487.50	
B. J. Wright	1,135.00	
O. Tremaine	185.00	
Untmployment Insurance	44.25	
		$10,286.75
Rent		1,436.39
Dr. Hossack—Honorarium		900.00
Printing, Postage and Stationery		422.44
Office Furniture and Equipment		88.50
Telephone and Telegraph		190.01
Miscellaneous Expense		203.91
Business Taxes		128.86
Audit Fees		100.00
Light		57.05
Bank Charges		37.22
Machine Servicing		22.05
Legal Expense		70.00
Bond on Treasurer		5.00
		$13,948.18
Travelling Expenses		69.37
Annual Meeting		373.74
Executive Luncheons		36.25
		$14,427.54
Exctss of Revenue over Expenditure for the period		3,314.96
		$17,742.50

Supplemental Statement of Assets and Liabilities January 1st to August 31st, 1949

32.

ASSETS

Cash:		
Petty Cash on Hand	$ 20.00	
Bank of Montreal	9,307,34	
		$ 9,327.34
Accounts Receivable:		
Review Advertisers	472.24	
Advance Expenses paid on Review	171.60	
Advance Travelling Expenses (J. G. Whitley)	250.00	
College of Physicians and Surgeons (Extra Mural)	300.00	
		1,193.84
Investments		10,066.94
		$20,588.12

LIABILITIES

Accounts Payable:		
Dr. J. C. Hossack, Honorarium		600.00
Deferred Income:		
Annual Meeting, Exhibitors' Deposits		1,960.00
Surplus Account:		
Balance as at December 31st, 1948	11,875.33	
Add: Excess of Revenue over Expenditure	6,152.79	
		18,028.12
		$20,588.12

Statement of Revenue and Expenditure January 1st to August 31st, 1949

33.

REVENUE

Fees Collected:		
480 Members at $27.00		$12,960.00
108 Members at 7.00		756.00
42 Members at 11.50		483.00
7 Members at 24.00		168.00
2 Members at 4.00		8.00
3 Members at 13.50 (½ Year at $27.00)		40.50
4 Members at 5.75 (½ Year at $11.50)		23.00
1 Member at 3.50 (½ Year at $ 7.00)		3.50
647		14,442.00
Less refund over-remittance 1948 fee		7.75
		$14,434.25

College of Physicians and Surgeons	1,600.00
Winnipeg Medical Society	600.00
Interest on Bonds	182.50
	$16,816.75

EXPENDITURE

General Expenses:		
Salaries:		
Dr. M. T. Macfarland, including expense allowance	$ 4,000.00	
H. M. Brown	1,320.00	
J. Allison	1,100.00	
B. J. Wright	880.00	
Unemployment Insurance	37.80	
		7,337.80
Honorarium, Dr. J. C. Hossack	$	600.00
Rent		984.00
Printing, Postage and Stationery		540.53
Office Furniture and Fixtures		436.67
Telephone		146.38
Business Tax		137.55
Audit Fee (Sept.. to Dec., 1948 Audit)		50.00
Light		33.90
Servicing Typewriters		20.85
Solicitors' Fees		20.00
Gold Medal		46.00
Subscriptions Medical Journals		27.56
Miscellaneous Expenses		8.29
Bond on Treasurer		5.00
Bank Charges		10.48
Executive Luncheons		29.10
Fee Taxing Committee, Workmen's Compensation Board		70.00
Travelling Expenses		94.06
Extra Mural		65.79
		$10,663.96
Excess of Revenue over Expenditure for the period		6,152.79
		$16,816.75

34.

Estimated Cost of Operation to December 31st, 1949

EXPENDITURES

Salaries	$ 3,950 00	
Rent	492.00	
Telephone and Light	80 00	
Printing, Postage and Stationery	100 00	
Miscellaneous	200.00	
Annual Meeting	500.00	
		$ 5,322.00

REVENUE

College of Physicians and Surgeons	$ 800.00	
Winnipeg Medical Society	300.00	
		1,100.00
		$ 4,222.00

I should like to point out that revenue from membership dues in 1950 will be reduced by approximately $1,300.00 by reason of the C.M.A. portion of fee collected being increased from $8.00 to $10.00.

Membership

35.

To the President and Executive of
The Manitoba Medical Association:

I wish to present the following report to date:

There are 787 Doctors in the Province of Manitoba	553	Winnipeg
	234	Rural
653 Active paid-up Members	476	Winnipeg
	177	Rural
8 Senior Members	4	Winnipeg
	4	Rural
1 Honorary Member	1	Winnipeg
125 Membership Fees Unpaid	71	Winnipeg
	54	Rural

This represents 84% paid-up membership.

36.

Of the 125 members whose fees are unpaid, 43 are retired or over 70 years of age, 8 are not practicing, 34 are recent registrants in the province, leaving a potential 40 from whom fees are collectible. On this basis, the percentage of paid-up membership is 94.9%.

Fifty members have been lost to us during the year, 11 are deceased and 39 have left the province.

Fifty-four new members have been enrolled to date this year.

I would like to draw to your attention the fact that, although the number of paid-up memberships to date is about the same as at the time of the Annual Meeting in 1948, the revenue in 1949 is greater by $726.75. This is due to 481 members having paid the higher composite fee of $35.00 as against 439 in 1948. Doctors on salary whose accounts are submitted on a fee-for-service basis are expected to pay the $35.00 fee.

This, I consider, a most gratifying report and I wish to express appreciation to all members for their co-operation in maintaining the high percentage of membership, and solicit your continued support.

Respectfully submitted.

C. B. Schoemperlen,
Chairman.

Economics

To the President and Executive of
The Manitoba Medical Association:

37.

I submit herewith the report of the Committee on Economics for the past year. Our time this year has been taken up in dealing with several items of negotiation with the Workmen's Compensation Board, and the Anaesthetists and Hospitals of Greater Winnipeg.

38.

Your Chairman of Economics was a member of the Workmen's Compensation Board Negotiating Committee, and you will receive a complete report in that regard from Dr. Henry Funk. From the point of view of the Committee on Economics, we feel that we have made more strides in principles than in actual gain in fees for the profession. It has now been established that a Fee Taxing Committee, nominated by the Manitoba Medical Association and concurred in by the Workmen's Compensation Board will adjust all fees referred to it, both by the W.C.B. and any practitioner who feels aggrieved at any fee which has been cut by the W.C.B. Payment to the members of this Committee has been made by the M.M.A. until recently, when the matter was referred to the College of Physicians and Surgeons, who then nominated the members of their own Fee Taxing Committee for this work and who will, therefore, pay for this service out of their own funds. It is my feeling that this change was unwise and not in the best interests of the profession. In favor of the transfer to the C.P. & S. was the fact that the M.M.A. would save considerable money and, secondly, that the C.P. & S. has legal powers which a committee of the M.M.A. does not have. On the other hand, since W.C.B. work is confined mostly to urban centres and the knowledge that the M.M.A. is more truly representative of the practising physician, it would seem that the M.M.A. would have been the proper body to sponsor this committee, particularly in view of the fact that the latter's committees have done all the negotiating with the W.C.B. and were conversant with the issues at stake. I would, therefore,

recommend that the incoming Executive reconsider this position in regard to the Fee Taxing Committee of the W.C.B.

39.

At the request of the Winnipeg Anaesthetists Society your Committee on Economics was belatedly called in to negotiate for them in regard to remuneration for services on a "fee-for-service" basis. It developed in the course of negotiation that the Anaesthetists of Greater Winnipeg were not unanimous in their demands and that they were split by internal dissension based, in some part, on differences in point of view and, in another part, by the fear of competitive practice. Therefore, your Committee was unable to be of much assistance in the settlement of this issue. Our advice to individual groups, however, was given, and separate arrangements have now been made between the various anaesthetist staffs and their hospitals. It is important that the profession realize that no progress can be made in any direction of economics unless we have unanimity in regard to the major principles involved. Such was not in evidence in the Anaesthetists-Hospital negotiations, and it is to be noted that we have lost the first round in our attempt to regain individual practice from the position of salaried employees of hospitals.

40.

You will also receive a report in regard to the progress made in the organization of Cancer Diagnostic Clinics under the Cancer Research and Relief Institute for rural Manitoba. From the point of view of your Committee on Economics, this is a most important development in the trend that is now proceeding towards the practice of medicine by the state or its agencies. Although this development may seem small it, nevertheless, sets a pattern of practice which has previously existed in tuberculosis and which will henceforth proceed in many other directions and lead to a centralization of diagnosis and treatment which is far from the free enterprise era that we have known. In spite of much discussion in which the status quo of practice was insisted upon, it finally evolved that we could not stem this change because, for years past, organized medicine, both here and in the United States, has sold the people on Cancer Clinics, without paying any attention to the economic principles involved in the establishment of such clinics. It is to be noted that this step has led us more towards state medicine than anything that we have heretofore sanctioned.

41.

Your Chairman has been on the Advisory Commission set up by the Minister of Health under the Health Services Act of Manitoba. Since the enactment of this legislation, several rural hospitals, both large and small, have been built in this province and have increased the availability of hospital beds close to the people. Many more are now in the process of organization but the shortage of nursing and technical staffs will, for a time, delay them. The trend, however, is there and, with time, it will gain momentum. In all hospitals of 28 beds or more there will be diagnostic services, both laboratory and X-ray, available to the people on a per capita cost of 60 to 75c per annum, in which a considerable part of the cost of operation will be borne by the Provincial Government and in which the capital cost for equipment will be wholly paid for by the Manitoba Government. This development is expected to be of great benefit to the people of this province and as urban centres can, by this legislation, avail themselves of the same treatment, it is reasonable to assume that they will eventually aspire to the same service. The Council of the City of Winnipeg has already gone on record and is investigating the possibility of setting up a centralized laboratory and X-ray service under this legislation. The Commission has at all times warned the Minister that hospitals of small bed content are uneconomical to operate and will, in due course, develop deficits which will somehow have to be met and will increase the cost of hospitalization, but, apparently political strategy has taken precedence over the probable economic loss.

The relationship of the members of the Commission with the Minister of Health have, on the whole, been amicable but there has been throughout its life a clash between the two parties as to what constitutes a policy and what constitutes administration. The Minister insists that administration of the Act remains within his hands and there are many instances on the border-line which the Minister has taken unto himself as being those of administration. It is clear that the majority of the members of the Commission feel that they are there more as a sounding board for policies of the government than as a real helpful body whose purpose it would be to give the people the best health provisions under the legislation. It is the opinion of your Chairman that, under no conditions, should we accept a Commission of this kind for the operation of any health insurance plan which may evolve for the medical care of the people in this province. This is a most important consideration for the maintenance of the independence of our profession and for the provision of good medical care for the people.

42.

Regarding the Manitoba Medical Service, you will be receiving a report from that body, but it is our duty to bring before the profession the consideration of various tendencies which are developing within that organization. Due to the very nature of the M.M.S. and its partnership arrangements with the members of the profession, it has become necessary to regulate and standardize both diagnosis and treatment in conformity with what is usual and what is unusual, no matter how scientific it may be. No plan of medical care can sponsor or pay for pioneering methods of diagnosis and treatment which are not generally accepted but which may be so in due course of time. It follows, therefore, that some of our members may feel restricted in their attempts to practise sound medicine as they see it but, of course, that is a price which we and the people will have to pay for the developing trend of the insurance plan. Consequently, there will always be room in the profession for a few outstanding practitioners to practise as individualists and not connected with any scheme. For political reasons, it has become necessary to extend the activities of the M.M.S. into the rural parts of this province and we feel that this move is by far our best means of opposing diagnosis and treatment control by government. The latter would inherently have many greater faults, both to the profession and the people, than those which we must accept from the M.M.S. Our M.M.S. is the most liberal of any plan in Canada in the provision of medical and surgical coverage, and it is that fact that will stand us in greatest stead when we have to face the issue of opposing the provision of medical care by the state. I would like to say to the profession that, no matter how irritating at times the regulations and the decisions of the M.M.S. may be to us in individual case, it still forms the best basis for combating a situation which would have more stringent and more irritating regulations and decisions. In regard to practice in rural areas under M.M.S. it would seem that the payment for mileage would represent a very important financial factor in its success. It is the opinion of your committee that payment for mileage should be an individual matter between the patient and his doctor and that this provision would minimize the frequency of unnecessary home calls, and at the same time enable the M.M.S. to maintain its financial stability.

43.

It is with regret that I have decided to relinquish the post of Chairman of Economics for the M.M.A., which I have had the privilege of holding for the last six years. It has been an onerous duty, which I have willingly and assiduously borne, because I have wanted to leave for the future members of the profession a set-up which at least is no worse than that which we inherited. I feel, however, that new blood and a new outlook would greatly strengthen the activities of this committee to the benefit of our membership, and it will prove a good training ground for future officers of the Association.

All of which is respectfully submitted.

A. Hollenberg,
Chairman.

Workmen's Compensation Board Negotiating Committee

To the President and Executive of
The Manitoba Medical Association:

44.

Since the Workmen's Compensation Board's fiscal year for 1949 has not terminated, no information is available as to whether or not there has been any actual percentage increase in payment to doctors for services rendered on the basis of the new fee schedule. Sheer conjecture leads me to say that there has not been, for, if anything, accounts have been reduced on a larger scale and regulations adhered to more rigidly, the latter being, in some instances, tantamount to refusal to honor an account.

Certainly, complaints from individual doctors on assessment of accounts by the staff of the Board are as numerous as heretofore, which all adds up to an unhealthy state of affairs. And it would appear that any increase in fees to the attending doctor has been offset by the aforementioned measures.

One particular complaint has been levelled at the $1.50 fee for an office visit. It has been asked—"Since when did doctors start dealing on a split-dollar basis?"—and it would appear that such criticism is perfectly justified.

To date no doctor has taken the trouble to make a written criticism of the new fee schedule, constructive or otherwise. I feel that comments, as to whethor or not the schedule is satisfactory, would be of material benefit in future negotiations. Too, any specific complaints backed by detailed information would be that much more helpful. It does not suffice for one or a few doctors to set forth the various shortcomings of our dealing with the Board, for the more representative the complaints are of the doctors at large, the more representative your Negotiating Committee is in its dealings with the Board.

Respectfully submitted.

H. Funk,
Chairman.

Workmen's Compensation Board Referee Committee

To the President and Executive of
The Manitoba Medical Association:

45.

I beg to submit herewith report of the activities of the above named Committee for the year 1948-49:

During this period your Committee met on thirteen occasions and dealt with a total of forty patients. There is nothing of particular interest to report.

Respectfully submitted.

C. E. Corrigan,
Chairman.

Manitoba Cancer Relief and Research Institute

To the President and Executive of
The Manitoba Medical Association:

46.

(1) So that the medical profession of Manitoba may be fully aware of the various aims and activities of the Cancer Institute, the Board of the Institute has decided that copies of the Annual Report should be mailed each year to every member of the Manitoba Medical Association. The report for 1948 has been distributed already and it is hoped that it has been carefully perused by all.

(2) With the object of providing a prepaid cancer diagnostic service for residents of rural Manitoba, the Union of Municipalities in November, 1948, requested the Provincial Government to levy a tax on the areas outside Greater Winnipeg, amounting to $20,000.00. They added the proviso that the Provincial Government contribute a like amount and there was the understanding that the Government of Canada would match the total. This tax has been levied and the sum of $80,000.00 is now available to the Cancer Institute. This is a preliminary figure and there is good reason to believe that larger sums of money will become available for the same purpose if the necessity arises.

After considerable thought and discussion, the Board of the Cancer Institute has submitted a plan to the Winnipeg General Hospital and the St. Boniface Hospital as an initial step in the diagnosis of cancer in rural patients. It proposes the establishment of Cancer Diagnostic Clinics at each Hospital, maintained by the available funds. If adopted, it is planned to include at least one other hospital in the near future. Up to the time of submitting this report (September 2nd, 1949), no reply has been received from the Hospitals. Should further developments arise before the Annual Meeting of the Manitoba Medical Association, a supplementary report will be made.

Respectfully submitted.

A. E. Childe,
Chairman, M.M.A. Cancer Committee.

Fee Committee

To the President and Executive of
The Manitoba Medical Association:

47.

In February, 1949, the Fee Revision Committee, composed of representatives of the Manitoba Medical Association and the Manitoba Medical Service, presented a report to the Executive of the Manitoba Medical Association, outlining a Schedule of Minimum Fees which was to be adopted by the Manitoba Medical Service as a basis for payment to doctors participating in that scheme.

In accepting the report, the Executive realized that no schedule of fees would ever be complete or satisfy all groups of our Association. Accordingly, as a means of settling disputes that would arise from time to time concerning fees, a permanent tribunal was considered a necessity, and a Fee Committee established. This consists of three members, The President of the M.M.A., or, in his absence, the Vice-President; a representative appointed from the General Practitioners; and a representative from the Specialists. This Committee was officially established in March, 1949.

In its short period of existence, the Fee Committee has had several points of dispute concerning fees presented to it. These have been dealt with or are in the process of being dealt with.

I feel that this Committee should prove itself to be one of immense value to the Association.

All of which is respectfully submitted.

Harold S. Evans,
Chairman.

Constitution and By-Laws

To the President and Executive of
The Manitoba Medical Association:

48.

Certain amendments to the Constitution of the Canadian Medical Association were passed at the Annual Meeting in June, 1949.

When the General Council of the Canadian Medical Association, at its meeting in June, 1948, was discussing the formation of a Section for General Practitioners it was pointed out that the Chapter of the Constitution and By-laws on "Meetings of Sections" did not permit, in its rigid interpretation, setting up this or any other Section in permanence. In practice this Chapter has never been strictly adhered to but it was felt that a change should be made so that the Sections would function in full accord with the letter of the Constitution.

49.

Therefore, the Committee on Constitution and By-laws, after prolonged study, proposed certain amendments to the Constitution which were duly considered and passed at the Annual Meeting in 1949. In substance, the Constitution now provides that, on application of twenty-five members of the Association, a Section may be organized for the purpose of developing interest of the members of the Association in any one field of medicine, scientific or economic. Each Section is to have a Chairman and Secretary who shall hold office from the close of one meeting until the close of the next meeting held during an Annual Meeting of the Canadian Medical Association. The Section will co-operate with the Central Programme Committee in arranging for its particular programmes to be held at the time of the Annual Meeting.

50.

In addition to the usual type of discussion, a Section may discuss matters related to its particular interests for the benefit of the Canadian Medical Association generally; it may present its views to the Executive Council which may, if it deems fit, have such matters considered by the Association as a whole. Any member of the Canadian Medical Association may attend any meeting of any Section but he will not be able to vote at such a Section unless he is registered therein before the commencement of the Session. With the approval of the Executive Committee, the Chairman of the Section may call a meeting of his Section at other times of the year as well as that of the Annual Meeting. Due notice of such special meetings must be given in the Canadian Medical Association Journal. For any adequate reason, such as a small number of registrations or the failure of a Section to hold a meeting, the General Council may, on the recommendation of the Executive Council, dissolve the Section and it shall not be renewed except upon a new application. At present there are sixteen Sections within the organization.

Also dealt with in the report was a note dealing with responsibilities of Officers of the Association and provision of a "mail ballot" of the Executive Committee.

Respectfully submitted.

Murray Campbell,
Chairman.

Legislative Committee of Fifteen

To the President and Executive of
The Manitoba Medical Association:

51.

No meetings of the Legislative Committee were held during the past year. Medical Legislature dealt with at the recent sessions of the Legislature was chiefly amendments to existing Acts which did not warrant, in our opinion, assembling either the Committee or the Committee of Fifteen.

During the last session of the Provincial Legislature several bills were presented which are of interest to the medical profession.

AN ACT to validate the establishment of Beausejour Hospital District.
AN ACT to amend the Child Welfare Act.
AN ACT to amend the Medical Act providing for the Remuneration of Council Members.
AN ACT to amend the Public Health Act.
AN ACT to provide special Assistance for Old Age and Blind Pensioners.
AN ACT to amend the Vital Statistics Act.
AN ACT to authorize the establishment of certain Medical Nursing Unit Districts.
AN ACT to amend the Health Services Act—provision among other matters:
(a) Respecting the expenses of the Boards of Local Health Units;
(b) Respecting the establishment of Diagnostic Facilities where there is no Local Health Unit;
(c) Respecting the making of grants to Outpost Hospitals.
AN ACT to incorporate "Winnipeg Clinic."
AN ACT to provide for the Granting of Aid to Municipalities for Social Assistance.
AN ACT respecting Pine Falls Hospital.
AN ACT to amend the Cancer Relief Fund.
AN ACT to amend the Mental Diseases Act.
AN ACT to amend the Lunacy Act.
AN ACT to amend the Basic Sciences Act—to remove the Practice of Dentistry from the application of the Act.
AN ACT to amend the Hospital Aid Act—to make further provision respecting the aid to be granted to Hospitals under the Act.

All of which is respectfully submitted.

Ross H. Cooper,
Chairman.

Liaison Committee, College of Physicians and Surgeons — Manitoba Medical Association

To the President and Executive of
The Manitoba Medical Association:

52.

Meetings of this Committee were held during the year, at which several items of mutual interest to the College of Physicians and Surgeons and ourselves were discussed and successfully dealt with.

The most important of these items was the arrangement whereby the College of Physicians and Surgeons undertook the responsibility of establishing a Fee Taxing Committee for dealing with disputed Workmen's Compensation Board accounts. This is a temporary scheme for a period of six months, at the end of which time its advisability will be reviewed.

The representatives from the College of Physicians and Surgeons have been extremely co-operative throughout all our meetings and it is with pleasure that I express to them our thanks for the courtesies which they have extended to us during the past year.

All of which is respectfully submitted.

Harold S. Evans,
Representative to Liaison Committee,
C.P. & S.-M.M.A

Group Insurance

To the President and Executive of
The Manitoba Medical Association:

53.

Since the inauguration of the Group Accident and Sickness Insurance Policy for the Manitoba Medical Association in December, 1948, three hundred and forty-two (342) members have purchased policies. This represents slightly more than fifty per cent of the total membership of the Association. Since inaugurating the scheme, the average member enrolment has been five new policy purchasers per month.

Four thousand, three hundred and sixty-three dollars ($4,363.00) has been paid in claims by the company to date. At the present time, three more claims are being processed. To date, a dispute has arisen over only one claim and the nature of this dispute has been such that there has not been any need for Committee interference.

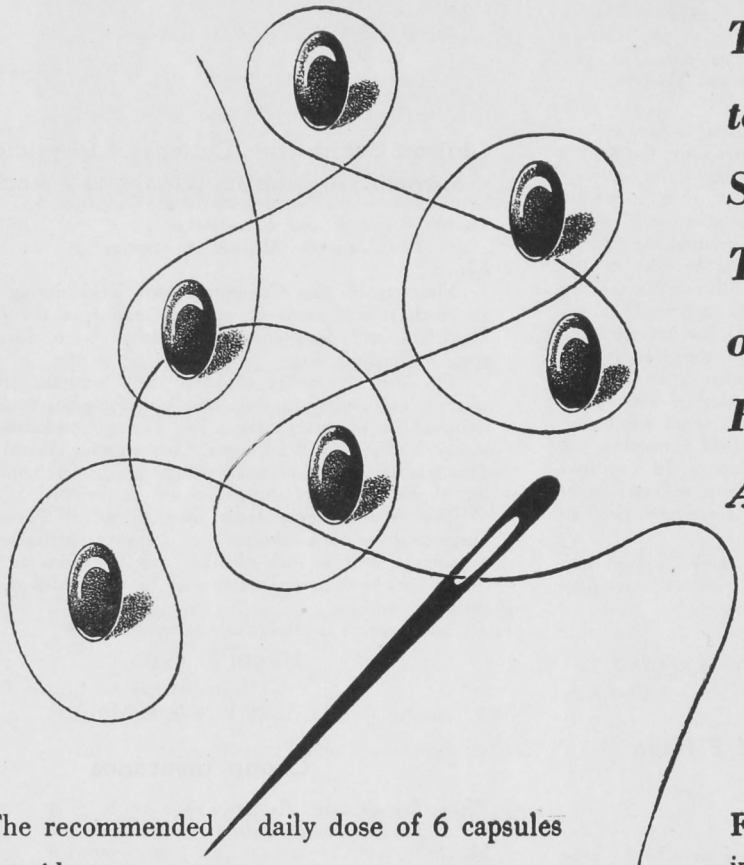
54.

A word of explanation is necessary in relation to the notices that will soon be received regarding the payment of premiums. The scheme was inaugurated December, 1948, and a thirty-day period was allowed for enrolment without medical examination to all members of the Manitoba Medical Association. This being a "group policy," any new members who enrolled after that time were given a proportionate reduction in the premiums paid. Since it is a "group policy," all premiums become due and payable again in December, 1949, and this is so, whether the policy was taken out during the initial period of enrolment or several months later. In other words, if a doctor enrolled in

Hemosules 'WARNER'

Trade Mark

A New Hematinic Preparation...



Tailored to the Successful Treatment of Hypochromic Anemias

The recommended daily dose of 6 capsules provides:

Ferrous Sulfate	(15 gr.)	972.0 mg.
Liver concentrate 1:20	(15 gr.)	972.0 mg.
Folic acid		5.1 mg.
Thiamine hydrochloride (vitamin B_1)		6.0 mg.
Riboflavin (vitamin B_2)		6.0 mg.
Niacinamide		24.0 mg.
Pyridoxine hydrochloride (vitamin B_6)		3.0 mg.
Calcium pantothenate		5.1 mg.
Ascorbic acid (vitamin C)		90.0 mg.

For Therapy

in hypochromic anemias: two (2) HEMOSULES* three times a day after meals.

For Prophylaxis and/or Maintenance

in conditions predisposing toward anemic states, *i.e.*, pregnancy, fever, respiratory disorders, infectious diseases, nutritional disorders, etc.: one to three (1 to 3) HEMOSULES* daily, or more, as prescribed by the physician.

HEMOSULES* 'Warner,' hematinic capsules, are available in bottles of 96.

*Trade Mark

William R. Warner & Co. Ltd.

727 King Street West, Toronto

is "group policy" in March, 1949, he would have paid only e coverage from March, 1949, to December, 1949, and in ecember, 1949, he becomes liable for the payment of the emiums to cover him until December, 1950, being allowed irty days grace.

Satisfaction has been expressed by every one contacted in gard to this policy. It has been amazing to learn of the mber of doctors who otherwise could not have obtained any surance and it is a source of gratification to know that this licy has been of great benefit to them. As in our previous port, we believe the policy to be a good one and we heartily dorse its continuation.

Lawrence R. Rabson,
Chairman.

Editorial

o the President and Executive of
The Manitoba Medical Association:

S.

We are reasonably satisfied with what we have been able present to our readers during the past year and it is gratifying to report that we have had favourable comments and quests for subscriptions from individuals and groups both thin and without the Commonwealth.

Such notice makes us more than ever desirous that the eview should reflect Manitoba Medicine as completely as ssible. Many worthwhile papers and interesting case reports e given in all the hospitals and at meetings inside and outde the City, but of these we receive only a fraction. We ould like the members of the Association to take a personal terest in the Review as their representative at home and oad, and to feel that their contributions are necessary to ake it completely representative.

S.

I owe my personal thanks to those who have assisted me— t. Israels, Dr. Borthwick-Leslie, Dr. Penner, Dr. R. Lyons, r. Whitehead, Dr. Lebetter, Dr. Coke and especially Dr. eikoff.

The Association owes a special debt to Mr. Gordon Whitley hose duties give him no opportunity to rest. The technical nd business affairs of the Review have for several years kept im at his desk daily. Partly to lessen his load and partly for ther reasons, we suggest that future volumes be of ten numers in place of twelve, by combining June and July, and ugust and September. The amount of material published uring the year would not be lessened but probably increased.

We would like our readers to remember practically that ut for the advertisers there would be no Review.

Finally, I wish personally to thank the Executive for its o-operation, consideration and encouragement.

Respectfully submitted.

J. C. Hossack,
Chairman.

Historical Medicine and Necrology

o the President and Executive of
The Manitoba Medical Association:

7.

It is with regret that your committee reports the passing of e following members of the Manitoba Medical Association nce the last Annual Meeting:

Doctors Leon George Benoit, Stanley Gordon Chown, illiam Alvin Cooper, Manly Finkelstein, Campbell Hamilton onro, John Robert Warburton Nicholson, Robert Francis orke, Elizabeth Steele, all of Winnipeg.

Doctors Daniel Baldwin, Benito; Ernest Bottomley, Dauphin, nd R. K. Chalmers, Miniota.

In the midst of the daily world of events, we sometimes nd time to pause and consider the passing of our colleagues. ere any of them with us today, they would undoubtedly deplore any eulogistic commentary, but your committee feels that Manitoba has lost fine men and women, whose work still lives silently after them, and if we were to publish the names of those for whom our late colleagues have done efficient, kindly, and sympathetic service, the list would be most imposing in its length and calibre.

Their memory should be an incentive to us all to do our daily work in such a manner that, when our time comes, May our earthly memory shine like theirs!

Respectfully submitted.

Athol Gordon,
Chairman.

Extra Mural

To the President and Executive of
The Manitoba Medical Association:

58.

Most requests from District Societies for speakers for local meetings have been made through the Association Office and this Committee. This procedure seems to have functioned satisfactorily throughout the year.

It is felt that even better service could be provided if a minimum of four weeks' notice was given on such requests, but it is realized that there are occasions when this is impossible, and during the year your Committee was able to fulfil the short notice requests without too much difficulty.

The following is the list of the meeting held during the year by the various District Medical Societies:

Brandon and District Medical Association:

September 8th, 1948, at Brandon:
- Dr. H. F. Cameron—"The Diagnosis and Treatment of Common Head Injuries."
- Dr. J. M. Kilgour—"Hyperthyroidism."

November 10th, 1948, at Ninette:
- Dr. Louis Cherniack—"Physical Examination of the Chest."
- Dr. A. M. Goodwin—"Management of the Third Stage of Labor."
- Dr. J. G. Fyfe—"Survey of Tuberculosis in Indians Committed to Brandon Sanatorium."

March 9th, 1949, at Brandon:
- Dr. F. A. B. Sheppard—"Chronic Duodenal Ulcer with Special Reference to the Hormonal Factor and Surgical Treatment."
- Dr. T. D. Wheeler—"Manitoba Medical Service."

June 1st, 1949, at Brandon:
- Dr. J. D. Adamson—"Poliomyelitis, with reference to recent epidemic at Chesterfield Inlet."
- Dr. W. F. Abbott—"Functional Bleeding."

Central District Medical Society:

January 25th, 1949, at Portage la Prairie:
- Dr. Gilbert L. Adamson—"Some Problem Cases in the Field of Psychosomatic Diagnosis."
- Dr. S. S. Peikoff—"Physiological, Diagnostic and Surgical Aspects of Jaundice."

March 15th, 1949, at Portage la Prairie:
- Dr. Maurice Berger—"Meningitis in Infants and Children."
- Dr. O. A. Schmidt—"Antepartum Haemorrhage."

April 18th, 1949, at Portage la Prairie:
- Dr. Kenneth Davidson—"Common Skin Disorders seen in the Summer Months."
- Dr. J. Wendell Macleod—"The Problem of Persistent Diarrhoea."

Northern District Medical Society:

December 1st, 1948, at Dauphin:
- Dr. E. W. Pickard—"The Early Use of Skin Grafts."
- Dr. J. C. Colbeck—"The use of a Provincial Pathological Service."

May 9th, 1949, at Dauphin:
- Dr. W. J. McCord—"Management of the Breech Presentation."
- Dr. N. P. Merkeley—"Reconstructive Surgery of the Hand."

rth of 53 District Medical Society:

nuary 26th, 1949, at Flin Flon:
Dr. C. E. Corrigan—"Round Table Discussion of General Surgical Problems."
Dr. R. W. Richardson—"Economic Problems of M.M.A. and Discussion re Manitoba Medical Service."

rthwestern District Medical Society:

ctober 6th, 1948, at Russell:
Dr. F. G. Allison—"Medical Problems Old and New."
Dr. C. C. Henneberg—"Toxaemias of Pregnancy."

uthern District Medical Society:

eptember 23rd, 1948, at Morden:
Dr. A. W. Andison—"Common Difficulties in the Management of Obstetrical Patients."
Dr. J. P. Gemmell—"The Management of Diabetes."
May 26th, 1949, at Altona:
Dr. C. H. A. Walton—"Bronchial Asthma."
Dr. F. R. Tucker—"Fractures, Sprains and Dislocations of the Ankle Joint."
Respectfully submitted.

P. K. Tisdale,
Chairman.

Maternal Welfare

the President and Executive of
The Manitoba Medical Association:

Your committee wishes to report as follows for the year 1948: The maternal death rate was 1.4 per 1,000 live births (there 19,088 live births in 1948). The figure for 1947 was 1.1, for 1946 1.7.

The causes of death were as follows:

1.	Abortion (induced)	2
2.	Pulmonary Embolism	3
3.	Infection	2
4.	Toxaemias	6
5.	Haemorrhage	7
6.	Obstetrical Shock	2
7.	Other causes	5
	Total	27
8.	Associated maternal deaths	3

The causes of death in No. 7 were:
1. Bronchospasm—Aspiration of Vomitus.
2. Rupture of Uterus.
3. Mesenteric Thrombosis with Embolism.
4. Childbirth—Indian.
5. Childbirth—Indian.

The causes of death in the associated cases were:
1. Rheumatic Heart Disease.
2. Pulmonary Tuberculosis.
3. Poliomyelitis—Chronic Tuberculous Meningitis.

The case records supplied by the Division of Statistics, artment of Health and Public Welfare, were carefully ied. The following facts were considered to be of particu- interest and importance:

1. Residence in City—3. All died in City Hospitals. Residence Rural—21. Of these, 8 died in City Hospitals, 9 died in Rural Hospitals and 4 at home. Residence Indian Reserve—6. Of these, 1 died in City Hospital, 1 died in City Sanatorium and 4 at home.
2. Of 28 confinements, 9 were attended by midwives (6 in Indian Reserves).
3. Of 30 maternal deaths, 8 were Indians—26.6%.
4. Autopsies were performed in 7 cases—23.3%.

No autopsy findings were supplied with the case records your committee recommends that in the future a copy of the pathologist's report be sent to the Division of Statistics. This would be of great help in the proper classification of the causes of death.

Your committee urges all physicians associated with maternal death cases to give future committees all the information possible by answering all the questions in the Department's inquiry form and to obtain permission for autopsy whenever possible.

All of which is respectfully submitted.

H. Guyot,
Chairman.

Sanatorium Board of Manitoba

To the President and Executive of
The Manitoba Medical Association:

62.

As your representative to the Sanatorium Board of Manitoba, I submit the following report:

The Board has met twice during the last six months and the Advisory Committee once. Reports have been received from the Superintendents of the sanatoria in Manitoba.

It is gratifying to know that the diagnosis and treatment of Tuberculosis remains on a high level. There has been a new era opened up during the last decade; Streptomycin has been made available, free of charge, to the patients and has proved to be of great benefit. Pulmonary resection for Pulmonary Tuberculosis is now a recognized procedure for certain cases.

The surveys being carried out through the Province continue to locate new cases of Tuberculosis or chronic spreaders of disease. A report by the Medical Superintendent of the Board "reveals that the incidence of new disease is on the increase"—no doubt due to the intensified case finding efforts. It is also stated "there is evidence that we may have reached the peak in new discoveries and a drop should now be expected." The surveys are discovering many non-Tuberculous Pulmonary Lesions and Thoracic Tumors, and thus bringing them under treatment earlier. This should lower the mortality from Thoracic Malignancy.

The Federal Health grants have allowed for X-ray units to be placed in the Winnipeg General Hospital, St. Boniface Hospital, Dauphin Health Units, Victoria Hospital and the Brandon General Hospital. These are for the routine X-raying of all admissions.

The Sanatorium Board of Manitoba is made up of men from the City of Winnipeg, and the Province of Manitoba, and from all walks in life. They unstintingly give their time and energy to the problem of Tuberculosis in this Province and one can only admire these men for the work they are doing.

Respectfully submitted.

M. B. Perrin,
Representative.

Post Graduate

To the President and Executive of
The Manitoba Medical Association:

63.

As your representative on the Post-Graduate Committee of the Faculty of Medicine, I wish to report that a three-day post-graduate course was held under the auspices of the Medical Faculty, at which a large attendance of general practitioners and health officers of the province were present. This course was well given and well received and numerous letters of appreciation were sent to the secretary of this committee. It is hoped that this course will be enlarged upon and that it will continue to receive the support of the M.M.A. and the profession at large.

All of which is respectfully submitted.

A. Hollenberg,
Representative.

Nutrition

the President and Executive of
The Manitoba Medical Association:

There has been no activity of the Committee on Nutrition ng the past year. The following item of correspondence referred to members of the Committee on Nutrition of Canadian Medical Association:

In 1937, the first edition of the Booklet, "What to Eat Healthy," for distribution to the public, was issued under joint auspices of the Canadian Medical Association and the adian Life Insurance Officers Association. Second and editions were subsequently printed. Information has received from the Canadian Life Insurance Officers ciation that they have now printed a fourth edition of 175,000 copies which they intend to distribute in Canada. is for your information.

F. F. Tisdall, M.D.,
Chairman, Committee on Nutrition,
Canadian Medical Association."

All of which is respectively submitted.

M. McLandress,
Chairman.

Editorial Board, C.M.A. Journal

the President and Executive of
The Manitoba Medical Association:

Your committee begs to report that Manitoba has con- ed to be well represented in the columns of the Canadian ical Association Journal. The following members have ributed articles during the past twelve months which have published in the Journal:

Doctors Elinor F. E. Black, Bruce Chown, A. Bryce, S. insky, F. G. McGuinness, C. E. Corrigan, D. F. Osborne, F. Abbott, G. S. Fahrni, J. R. Martin, F. A. L. Mathewson, M. Lederman, Ross Mitchell, G. S. Musgrove, C. B. emperlen, C. M. Strong, P. H. T. Thorlakson, C. H. A. on.

Manitoba Notes and Abstracts relating to Obstetrics and ecology have originated in Manitoba.

Respectfully submitted.

Ross Mitchell,
Chairman.

Public Health

the President and Executive of
The Manitoba Medical Association:

There were no separate meetings of this committee arranged ng the past year, so that there is nothing to report.

Respectfully submitted.

E. K. Cunningham,
Chairman.

Credentials and Ethics

the President and Executive of
The Manitoba Medical Association:

As no problem on Credentials or Ethics has been submitted the Provincial Committee during the past year, there is ing to report.

Respectfully submitted.

I. O. Fryer,
Chairman.

Medical Education

To the President and Executive of
The Manitoba Medical Association:

68.

As the Committee on Medical Education held no meetings during the past year, the Chairman has no report to submit.

L. G. Bell,
Chairman.

Industrial Medicine

To the President and Executive of
The Manitoba Medical Association:

69.

There were no activities on the part of this Committee during the year ending September, 1949.

Respectfully submitted.

Hugh Malcolmson,
Chairman.